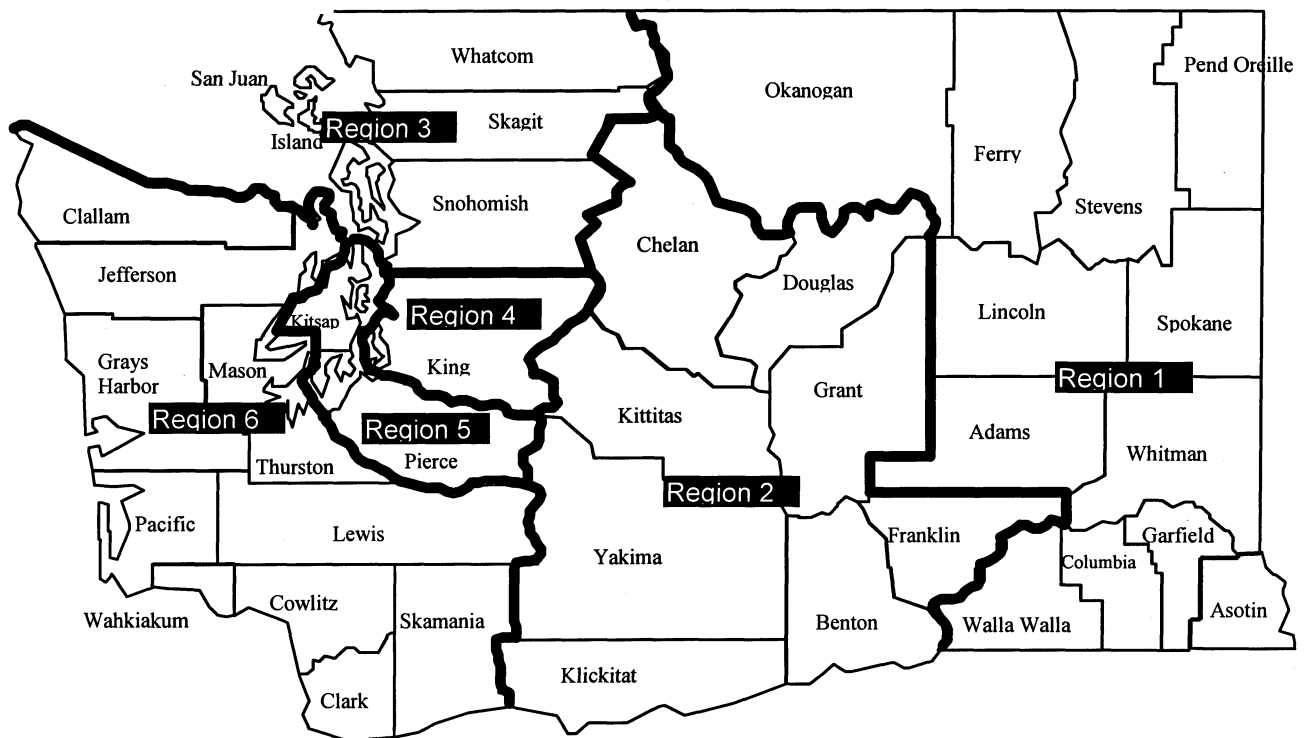


2002- 2003 WASHINGTON STATE HIV PREVENTION PLAN



ATTACHMENTS

WASHINGTON STATE HIV PREVENTION PLAN

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**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 1

**ELLENSBURG
DOCUMENT**

HIV Prevention Planning Retreat -Ellensburg, October 23rd and 24th

The participants in this retreat concluded that given the strengths and weaknesses of HIV Planning processes that were identified by the group, there was a need to clarify the various roles and responsibilities by each of the Planning Agencies and Groups. It was also concluded that all related prevention funding needed to be taken into account, not just CDC prevention funds and that the new planning process should be effective for funding starting January 1, 2000. DOH, AIDSNETs, SPG, and the RPGs should begin determining intermediate dates, due dates, etc. based on the required submission of the federal grant application around October 1, 1999.

At a practical level, this means that the allocation process should target 100% of available CDC resources, and a minimum of 50% of state Omnibus funds available within the region should be responsive to the priorities established by the regional planning process. Not all state Omnibus funds can be allocated through this process, as the AIDSNETs and local health jurisdictions are charged with certain responsibilities under the AIDS Omnibus law.

I. Regional Planning Groups (RPG)

- A. Responsible for regional planning (e.g., needs assessment, identifying populations at risk within the region, prioritization, evaluation, Parity Inclusion Representation) in accordance with the guidance developed for Washington State (see SPG) and the supplemental guidance on HIV prevention community planning issued by the CDC.
- B. Responsible for participation in statewide planning process, including representation on the State Planning Group.
- C. Responsible for letter of concurrence (or nonconcurrence) to DOH that the proposed allocation of resources (CDC and state Omnibus) by the regional AIDSNET is responsive to the priorities established in the regional HIV prevention plan.

II. Regional AIDSNET

- A. For allocation and disbursement of prevention funds for which they are responsible, the AIDSNETs are subject to state and federal law and the Washington State Guidance (see SPG) and Regional Planning processes and priorities.
- B. Provides standardized, periodic reports to the SPG, DOH and Regional Planning groups on its regional prevention activities.
- C. Provides necessary administrative and technical support to the RPG.
- D. Follows-up on recommendations from the DOH and the SPG.
- E. Responsible for the submission of the regional HIV prevention plan to the SPG.
- F. In collaboration with the DOH, develops report formats for: regional prevention plans; proposed allocation of funds; due dates; and other reports.
- G. In collaboration with the SPG, responsible for identifying the need for special training, implementation, and oversight assistance to support new or innovative regional projects to address unmet prevention needs.

- H. Will assist the RPG and SPG on assuring that PIR is met.

III. State Planning Group (SPG)

- A. Responsible to develop an umbrella guidance including both minimum requirements and recommended guidelines for statewide and regional HIV Prevention Planning in Washington State that encompasses all HIV prevention needs and resources in the state; other guidance as requested or agreed to by the RPG; and other guidance as required by the CDC to meet planning requirements.

This guidance should result in HIV prevention plans which includes all of the nine elements of a comprehensive HIV prevention plan as identified by the CDC supplemental guidance.

The umbrella guidance shall include:

1. Identification and prioritization of defined populations with HIV prevention needs statewide;
 2. A uniform epidemiologic profile that can be supplemented with regionally available data reflecting the fullest picture possible of the epidemic;
 3. Standardized guidelines for minimum quantitative and qualitative data collection that can be supplemented with regionally available data;
 4. Standardized guidelines for the collection, analysis and use of data for the CRI. Statewide CRI data may be supplemented with other regionally available data;
 5. A standard decision-making framework for prioritization of populations at risk and assessment of prevention needs;
 6. A listing of effective strategies and interventions for defined populations at risk.
 7. Goals for the achievement of parity, inclusiveness, and representation (PIR) at the SPG and RPG levels.
- B. Annually reviews regional plans and proposed AIDSNET allocation of funds to determine the extent to which:
1. The umbrella guidance for planning has been followed in the regional planning process including, but not limited to, PIR.
 2. The regional plan adequately describes the process and outcomes of the regional planning process.
 3. Materials explain any discrepancies between the priority needs identified in the regional plan and the regional allocation of funds.
 4. The RPG letter of concurrence adequately expresses concurrence/ nonconcurrence that the allocation of resources is responsive to the regional plan.
- C. Develops recommendations to DOH for follow-up with regional AIDSNET if regional priorities and the SPG guidance were not followed during or resulting from the regional planning process.
- D. With staff support from DOH and based on review of regional prevention plans:
1. Identifies statewide unmet needs that may not be identified or addressed by the regional planning process and/or

2. Recommends special training, implementation, and oversight assistance to support regional innovative projects to address unmet prevention needs.
3. Develops the statewide HIV prevention plan based on the six regional plans and the identified statewide unmet needs. "Statewide unmet needs" are defined as those that will have a significant impact on HIV transmission in all regions of the state. This does not mean the program or intervention activity is carried out in each region, but does mean that at least five of the six regional planning groups agree that the program or intervention will have a significant impact throughout the state.
4. Reviews the DOH proposed funding application to the CDC and provides annual letters of concurrence/nonconcurrence to the CDC that the proposed application to the CDC is responsive to the statewide plan;

IV. Department of Health (DOH)

- A. Provides technical assistance for planning and program implementation (including data collection, regional epidemiology, effective strategies, and evaluation).
- B. In collaboration with the SPG responsible for writing and submitting the statewide prevention plan.
- C. Responsible for writing and submitting an application to the CDC for federal funding of the HIV prevention project.
- D. Responsible for fiscal and programmatic contract monitoring as appropriate to state and federal funding sources.
- E. Follows up with Regions on assurances and recommendations from SPG.
- F. Follows up with the appropriate agencies and entities to assure compliance with planning guidance and program implementation and program evaluation.
- G. Negotiates with the regional AIDSNETs to reach mutual agreement on the allocation of prevention funds to (1) address the SPG identified statewide unmet needs that were not identified or addressed by the regional planning process and/or (2) support a special training, implementation, and oversight assistance program to assist new or innovative regional projects to address unmet prevention needs.
- H. In collaboration with the regional AIDSNETs, develops standardized report formats for regional prevention plans, proposed allocation of funds, etc. and due dates.
- I. Collates, compares, analysis and summarizes regional prevention plants to facilitate the SPG review process.
- J. Provides necessary administrative and technical support to the SPG.

Letter of Understanding

On October 22 and November 24, 1998 authorized representatives of the stakeholder groups identified in the “Ellensburg Document” (Appendix 2) as having responsibility for planning HIV prevention activities met to:

- Achieve common understanding of terms included in the Ellensburg Document; and
- Negotiate to reach consensus on unresolved issues.

The stakeholder groups participating in these meetings were the AIDSNET Council, state Department of Health (DOH), regional planning groups (RPGs), and state HIV prevention planning group (SPG). Participants in the October and November meetings are identified in Appendix I.

The October 22 meeting focused on the identification of terms needing to be clarified, areas in need of mutual agreement, and the process for achieving consensus or agreement. At this first meeting, there was agreement on the process for future modification of this Letter of Understanding (LOU) or the Ellensburg Document (ED). It was agreed that any group may request the LOU be changed, and that all groups should review the ED and give feedback to the SPG. It was also agreed that the SPG should poll members regarding the ED, and if appropriate, schedule a review in December 1999.

Consensus understandings achieved by the LOU meeting participants

1. The Ellensburg Document sets the framework and context for HIV prevention planning in Washington State.
2. Each of the groups involved in HIV prevention planning have equal voice, although their respective roles and responsibilities may differ.
3. Community HIV prevention planning processes that support the Centers for Disease Control and Prevention’s core objectives provide the best opportunity for successfully competing for all prevention funds that might be available at the local, state, national and international levels.

What does 50% of Omnibus funds mean?

The language in the second paragraph of the Ellensburg Document is sufficiently clear – “a minimum of 50% of state Omnibus funds available within the region should be responsive to the priorities established by the regional planning process”. The ED did not intend to identify or specify recipients of these funds. This is a regional decision.

How will compliance with the requirements of the Ellensburg Document be assured?

DOH will provide technical assistance to regional planning groups and regional AIDSNETs based on the review of regional plans and AIDSNET allocation of funds as described in sections III B and C of the Ellensburg Document. DOH has the authority to reduce funding to a region under RCW 70.24.400 for misfeasance, malfeasance or nonfeasance.

Do the priorities of the regional planning groups have to be identical to the SPG priorities?

No. The SPG ranking of priority populations serves as statewide guidance. RPGs are expected to re-rank priority populations based on regional epidemiologic profiles and needs, using the model for decision making established through guidance from the SPG. All populations prioritized by the SPG should be considered by the RPG in the prioritization process, but this does not imply an identical ranking, or an expectation that all populations will be addressed through funding decisions.

Should there continue to be a “set aside” for statewide unmet needs?

A set aside for statewide unmet needs should continue, guided by the following principles:

- Should not be used for “local” programs, except for “demonstrations” (e.g., where effective interventions for a particular population have not been identified).
- Should have as a goal, minimizing the need for set aside funds.
- Current set aside funds should be reduced. Ten percent of the CDC prevention project funds should be set aside, with recognition that CDC reductions should first come from the set aside dollars, as long as at least \$250,000 remains. If funding from CDC results in a set aside greater than \$400,000, the amount above \$400,000 should be made available for regional allocation. [\$250,000 → 10% → \$400,000]
- In calculating the ten percent set aside amount, monies are not included which are specifically directed by the CDC for particular populations, interventions, or recipient organizations (e.g., recent federal funding for services to racial/ethnic minorities by community-based organizations).
- The planning and allocation processes should not inhibit DOH opportunities to compete efficiently and in a timely way for new federal funding.
- RPGs and regional AIDSNETs should provide a report to the SPG identifying the new activities or services enabled by a shift of funds from the statewide set aside to the regional allocation process.

Letter of Understanding
Page 3

Consensus was reached on all of the above issues.

Each body represented in this process will designate who should sign this Letter of Understanding. Signature indicates the willingness of that group to actively support this Letter of Understanding.

Signatures: (Original signers were:)

F. Cruz-Uribe 2/4/99
AIDSNET Council Date

Maxine Hayes 4/7/99
Department of Health Date

Muril H. Demory 2/10/99
Region 1 RPG Date

Leslie K. Rivera 2-25-99
Region 2 RPG Date

Daniel R. Combs 2/25/99
Region 3 RPG Date

Kris Nyrop 2-25-99
Region 4 RPG Date

Jennifer P. Johnston 2/8/99
Region 5 RPG Date

Clain E. Lust 3/22/99
Region 6 RPG Date

Edward C. Foster 2/25/99
SPG Date

LOU/Final 12/15/98

**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 2

**EFFECTIVE
INTERVENTION
MATRIX AND
LITERATURE
REVIEW**

Notes on general reviews of interventions for MSM

OTA *The Effectiveness of AIDS Prevention Efforts*

Multiple session, small-group counseling can result in both short-term and long-term increases in condom usage and less unprotected sexual activity, including with African-American MSM.

HIV counseling and testing may play a role in risk reduction for MSM, but difficult to isolate effects of c&t from other factors that may affect risk behavior.

Community-level interventions (CLI) with pre-post evaluation suggest CLIs have effect (e.g., STOP AIDS Project in SF, Kelly's work with popular opinion leaders).

What Works in HIV Prevention for Gay Men (2001) AIDS Action.

Covers interventions that have been shown to be effective.

- Peer leadership and role modeling in communities (popular opinion leaders, Kelly; The African-American Men's Health Study, Peterson).
- Interventions for the hard-to-reach (AIDS Community Demonstration Project; Mpowerment; Hermanos de Luna Y Sol (HLS))

HLS developed by Rafael M. Diaz and Jose Ramon Fernandez-Pena for immigrant Spanish-speaking MSM in SF. Focused on modifying high-risk sexual behaviors believed to result from sociocultural factors that contribute to decreased self-esteem, perception of low sexual control, sense of social isolation, and fatalism about HIV infection. Three components: (1) bar outreach and recruitment of gay Latino bar patrons using short survey to stimulate discussion (after interviews, given condoms, tokens for non-alcoholic drinks, cards for program—those who called were enrolled in group sessions); (2) 4 small group sessions each lasting 2 hours. Facilitated by 2 Latino gay men trained in health education (sessions devoted to exploring lives as Latino gay men, impact of AIDS on lives and sexuality, practicing safer sex, training in how to use a safer sex journal); (3) follow-up activities to ensure that sustained behavior change. Preliminary pre post data showed increases in anal intercourse, but decreases in number of sexual partners. 80 percent of those reporting increases in AI reported consistent condom use. For all men in follow-up sample, consistent condom use increased from 50 to 58 percent for IAI and from 33 to 58 percent for RAI.

Kegeles SM and Hart GJ (1998) Recent HIV-prevention interventions for gay men: individual, small-group and community-based studies. *AIDS* 12 (suppl A): S209-S215.

Reviews studies published in or since 1995.

- *Individual-level*: Couldn't locate any new research looking at efficacy of C&T or other individual approaches. Notes that HIVNET in midst of study on client-centered, multiple-session counseling. Also Coates and Katz are looking at offering PEP (post-exposure prophylaxis) in 3 SF clinics.
- *Group-level*: Reviews Peterson et al. (1996) and Choi et al. (1996) (see summary grid).

- *CLI*: Reviews Kelly's studies (see grid), Kegeles (see grid), and AIDS Community Demonstration Projects (see heterosexual grid for summary of ACDP format).
- Discusses recruitment difficulties for individual- and group-level interventions. Only men who already believe that prevention is important or that they are at risk will participate.

Kelly JA (2000) HIV prevention interventions with gay or bisexual man and youth. *AIDS* 14 (suppl 2): S34-S39.

Reports on same interventions as 1998 review above.

MSM-IDU

The only mention of an effective intervention for MSM-IDU is from the JAMA web site, not in a published study. On July 6, 1999 Reuters Health Information reported on the 61st Annual Scientific Meeting of the College on Problems of Drug Dependence. One presentation dealt with a behavior drug treatment intervention for gay and bisexual methamphetamine users. The Friends Research Institute in California randomly assigned 68 clients to one of four 16-week behavioral treatment programs. Treatment conditions included contingency management, relapse prevention, contingency management plus relapse prevention, and relapse prevention combined with gay-specific HIV risk reduction. Under contingency management, subjects are paid increasing amounts for money as their number of successive negative urine samples increases. Relapse prevention consisted of cognitive and behavioral strategies for instilling abstinence without monetary incentives.

Preliminary findings for 43 clients showed that treatment retention and effectiveness was higher for subjects in the two contingency management groups and lowest for those in the relapse prevention group. The addition of gay-specific HIV risk education was not associated with greater retention or treatment effectiveness. Regardless of treatment group, over the 16-week treatment period participants significantly reduced the number of sexual encounters while high, episodes of receptive AI without a condom, and number of sexual partners. [No more details available.]

MEN WHO HAVE SEX WITH MEN

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Individual-Level			
Fisher et al. (1999)	HIV+	Preliminary report. 107 HIV+ MSM who had anal sex in preceding 4 months with a male partner. Using motivational interviewing, assess values, beliefs, attitudes, and details on 4 most recent anal sex partners. In discussion, highlight discrepancies between values, beliefs, and risky sexual behaviors.	Six-month follow-up data show a 31% reduction in the proportions of participants reporting unprotected anal sex with a partner of negative or unknown serostatus.
Group-Level			
D'Eramo et al. (1988)*		619 participants placed into four programs; 1) safer sex written guidelines; 2) lecture/discussion on AIDS information and safer sex guidelines; 3) verbal and written presentation of eroticized safer sex guidelines; and 4) visual presentation of sexually explicit safer sex guidelines.	Participants in program 4 were most effective in reducing unsafe sex at 2 month follow-up.
Coates, et al. (1989)*		64 HIV+ gay men randomly assigned to 1) eight 2-hour weekly group stress reduction training session plus one all day retreat, or 2) a 2 month wait-list control.	At 2-month follow-up, experimental group had fewer sexual partners in the past month than control group (1.1 vs. 2.3).
Valdiserri, et al. (1989) ♦♦▼		584 participants randomly assigned to 2 peer-led interventions: 1) a 1-session, 60-90 min small group lecture on HIV transmission, clinical manifestations of HIV infection, condom use, and meaning of HIV antibody test results or 2) small group lecture plus 50 min. skills training on safer sex negotiation.	Condom use during insertive AI higher among skills training (36% at baseline, 69% at 6-month follow-up, and 80% at 12 months than among single lecture group (44% at baseline, 43% at 6 months and 55% at 12 months). No difference in condom use during receptive AI at both follow-ups. Assessment of cost effectiveness showed cost savings from program. Results robust to changes in modeling assumptions (Pinkerton et al., 1997)

MEN WHO HAVE SEX WITH MEN

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Kelly et. al (1989) *♦♦		104 participants randomly assigned to 1) 12 weekly sessions, 75-90 min small group counseling which provided AIDS risk information, behavioral self-management, assertiveness training, and relationship-building skills or 2) a wait-list control	Skills training resulted in less unprotected anal sex (mean=2.3 for experimental group; 3.3 for control group) and higher condom use during anal sex in the past 4 months (experimental group used condoms during 66% of all anal episodes; 19% for control group). Behavior change maintained at 8-month follow-up
Kelly et al. (1990) ♦ *▼		Purpose of study to evaluate impact of more abbreviated intervention than Kelly et al. (1989) above. 15 participants received 7 small group sessions, 60-90 min each. Covered AIDS risk information, behavioral self-management, assertiveness training, pride and support issues. One 3-month follow-up booster session.	At 8-month follow-up, UAI in past 4 months fell from .93 to .21 mean occurrences. Proportion of all intercourse occasions where condoms used increased from 72% to 90%. Risk index (risky practices x no of partners) decreased from 4.7 to 1.4.
Choi et al. (1996)	API	Brief group counseling for self-identified gay API in SF. N = 329 (208 intervention, 121 control). Randomized in single-session, 3-hr skills training group or wait-list control. 4 components: development of positive identity and social support, safer sex education, eroticizing safer sex, negotiation.	Baseline and 3 mo follow-up. 46% reduction in expected number of partners at follow-up for intervention group. Chinese and Filipino men reduced UAI by more than 50%. Comment: The stats for change in number of partners in past 3 mos. are odd and I don't understand Poisson modeling well enough to understand them. Avg. change for experimental group -.28 (median 0, range -25 to +45) compared with +13.9 for controls (median 0, range -15 to +98). Poisson model shows 46% reduction in expected number of partners at follow-up.

MEN WHO HAVE SEX WITH MEN

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Peterson et al. (1996) ♦†	POC (African-American)	318 African-American MSM in SF from 1989-1991. Randomly assigned to 1-session, 3-session, or wait-list control group. 3-session non-peer mediated counseling consisted of 3-hour group sessions one week apart with 10 participants in each group. Components: self identity and development of social support, AIDS risk education, assertiveness training, behavioral commitment. Attendance problems: 53% of men in 3-session attended at least 1 session (12%, 16%, 25% respectively). 45% of men in 1-session group attended.	Participants in 3-session intervention showed significant reduction in UAI at both 12 and 18-month follow-ups. Reduction from baseline was 45% to 20%. Risk behavior in control group remained constant and declined only slightly in 1-session group. <u>Comment:</u> In spite of blocked randomization, control group was much less risky at baseline. No significant differences between control group and 3-session at follow-ups.
Rotheram et al. (1994) ♦	Youth/ Street	138 participated, age range 14-19. 20-session intervention, 90-120 min/session, offered 2-3 times/week after school. Non-peer led with HIV information, coping, skills training, access to health care, social support, private counseling. 20 session intervention, 90-120 min. each, 10 youth per session. No control group.	Follow-up at 3,6,12 months. Protected AI increased from 60% to 78%. Less risk in past, no commercial sex work, and attending more sessions = more risk reduction. Of racial/ethnic groups African-Am reduced risk most (PAI increased from 36% to 84%). <u>Comment:</u> Complicated multivariate analysis, hard to summarize adequately.
Community-Level			
Kelly et al. (1992) ♦♦††		Trained 924 opinion leaders (POLs) in an intervention city. Lagged implementation into 2 other cities. Surveyed bar patrons in all 3 cities at same time points. POLs received 4 sessions, 90 minutes each, covered HIV education and communication strategies. POLs then agreed to have 14 peer conversations about AIDS risk reduction (personal endorsement). Study conducted from 1989-1991.	Significant reductions in the mean % of men who practiced UAI in Biloxi (24% at 3 month follow-up) and Monroe (21%) but the 15% decline observed in Hattiesburg insignificant. Also, significant change in the % of men with multiple sexual partners. At 3-year follow-up (St. Lawrence et al., 1994), reductions in UAI and increases in condom use continued to occur.

MEN WHO HAVE SEX WITH MEN

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Kelly et al. (1993)*		For a 5-week period, trained opinion leader in four experimental cities engaged in peer conversations about the benefits and appropriateness of risk behavior and change, strategies to implement change, and risk misconception at local gay bars. Four matched cities were selected as control. 701 participants. See also Kelly et al. (1997)	The community intervention led to decreased proportions of men who engaged in any UAI (from 33% at baseline to 25% at 9 month follow-up), unprotected insertive anal sex (27% to 17%), and unprotected receptive anal sex (22% to 16%) in the experimental relative to control cities (little change observed at the follow-up).
Kegeles et al. (1996) +▼	Young Gay men (18-29)	Peer-led program with three components: outreach (formal and informal), small group and publicity campaign. Program run by Core Group and community advisory board of "elders". Groups were one-time 3-hour small group meetings (8-10 people), which focused on safer sex and HIV information, communication and interpersonal skills. Independently from the prevention program, a cohort of young gay men (n=300) surveyed in intervention and comparison community. Wait-list control design.	Reduction in all UAI from 41% to 30%, from 20.2% to 11.2% with non-primary partners and from 58.9% to 44.7% with boyfriends. No significant changes in comparison community. Reductions sustained 1 year later with non-primary partners, mixed results for sex with boyfriends (Kegeles et al. 1999). 87% of intervention community respondents had heard of project and 77% had experienced at least two project activities. High risk-taking men less likely to attend small groups, volunteer for outreach, or be Core Group member.

MEN WHO HAVE SEX WITH MEN

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Street Outreach			
Hospers et al. (1999)		Program in the Netherlands that trains volunteers to go into cruising areas (CA) to talk with CA visitors about importance of safer sex. Give risk information, explain why safer sex important, brochure, condom and lube. No conversations with visitors that didn't want to talk.	Post-intervention survey of people who said had at least one conversation with a volunteer (conversation group, n=172)) and those who hadn't been approached but would have had a conversation (no conversation control group, n=190). Conversation group had significantly higher condom use for insertive and receptive AI. MSM increased condom use more than MSMW. Conversations had no effect on intention to use condoms for AI.
HIV Antibody Counseling & Testing			
Higgins et al. (1991)		Overall review of 50 C&T studies. 17 of these look at effect of C&T on behavior change (condom use, reduction of sexual partners) of MSM.	For MSM: All studies reported risk reduction among tested and untested men, a few reported greater decreases in seropositive than seronegative. States that its hard to draw firm conclusions about impact of C&T on MSM risk behavior.
No reviews on Mass & Other Media, Social Marketing, Hotlines, Clearinghouse, or Partner Notification			

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IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Individual-Level			
Stephens et al. (1991) ◆★	POC (African- American Male)	322 (mostly street addicts not in tx) participated in 1:1 counseling delivered by a professionally trained health educator and lasted 45-60 minutes. Session provided basic information on HIV transmission using a segment of a film; discussed sexual risk reduction and condom use; covered ways to reduce risk due to injection drug use and ended with information on HIV testing.	Pre-post results compared baseline to 3-month follow-up interview. Percent reporting injecting decreased from 92 to 71, sharing decreased from 67 to 24. Didn't ask questions about sexual risks.
Group-Level			
El-Bassel et al. (1992) ▼	POC/Women (African- Am/ Hispanic)	NYC. 62 African-American and Hispanic women enrolled in a large methadone program for a least 3 months. Intervention consisted of five 2-hour group session in skills building for 9 to 10 women. Group leaders were female drug counselors who received an additional 20 hours of intervention training. First 2 sessions focused on HIV transmission information and prevention techniques. 3 rd : discussion and role-playing about condom use. Final 2 sessions focused on assertiveness training, problem solving, and communication skills. Comparison group received 1 session of AIDS info routinely provided by the clinic.	15-month follow-up. Compared to the information-only group, women in the skills-building group showed an increase in frequency of condom use and comfort talking about safer sex with partners. Also, perceived selves more able to reduce exposure to AIDS. The groups did not differ significantly in number of sex partners.
De Jarlais et al. (1992) ◆		Study to see if teaching safer injecting practices would cause injecting to increase among drug sniffers. 104 NYC HIV-heroin users who were using intranasally (sniffing) as their primary route of heroin use and who had injected no more than 60 times in the previous two years. Trained peer-mediator conducted four 60-90 minute group session over a two-week period, which included AIDS 101, safer injection, sexual behavior, and drug abuse treatment programs. Controls filled out surveys that were in-depth interviews.	Significant lower level of injection at follow-up (average follow-up period = 9 months). Did not prevent all drug injection. 15% assigned to the intervention injected during the follow-up period, compared with 33% of those assigned to the control group. There however was no evidence that the intervention was effect at improving safer sex.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Malow et al. (1994) ♦	POC/ Drug use (African – American – male-cocaine users)	152 African American males at in-patient tx program participated in group-level sessions. Non-peer led, held for 2 hours over 3 consecutive days, 6-8 people. 1 session on HIV knowledge/ risk, demonstrated cleaning works. 2 nd session on safer sex, condoms use, condom negotiating, and skills-building exercises. Final session on review and discussion of HIV testing procedures.	47.5% of intervention group participants reported having more than one partner at three-month follow-up compared to 76% at the baseline. In the comparison group. The change from 76% at baseline to 59% at the follow was considered to be not statistically significant. Sexual risk taking decreased from 75% at baseline to 32% at follow-up.
Magura et al. (1994) ▼	Young POC (African-Am/Latino) Jail/ drug users	NYC DOC Adolescent Reception and Detention Center. 157 youths aged 16-19, most were African-American or Hispanic. 4 1-hour small-group sessions of eight led by male counselor which focused on health education issues relevant to male adolescent drug users, with an emphasis on HIV/AIDS. Group activities included role-play and rehearsal techniques.	Youth in the intervention were more likely to use condoms during vaginal, oral or anal sex, had fewer high-risk sex partners, and had more favorable attitudes toward condoms than youth not in the intervention.
Schilling et al. (1991) ♦	Women/ POC/ Methadone Tx	91 African-American and Hispanic women enrolled for at least 3 month in five clinics in a large methadone maintenance program in NYC. Non-peer led skills-building groups held five 2-hour sessions offered to groups of 9-10. Topics included: HIV 101; identification of high-risk sexual practices; discussion of barriers to adopting safer sex practices (2 sessions); discussed their negative association with condoms; practiced condom use skills; and role-played negotiation of condom use (1 session); assertiveness; problem solving; and communication skills involving safer sex scenarios (2 sessions). Control group was provide one single HIV information-only session.	The skill-building intervention group showed statistically significant higher use of condoms than those in the control group at follow-up. Participants also more comfortable taking and carrying condoms, talking about safer sex with partners, had more favorable attitudes toward condoms. No drug use differences between groups. <u>Comment:</u> spg summary says 15-month follow-up. I could only find reference to a 2-week post.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Cottler et al (1998)	POC/ African-Am	St. Louis Program (EachOneTeachOne). N=725, 61% male, 93% African-American. A peer role model for out-of-tx crack cocaine users and IDU. Role Models conducted outreach to reach persons on the street spending 5 to 15 minutes contact with users, then random assignment to standard (SI) or enhanced intervention (EI). All participants in two sessions of drug and HIV info and C&T, then EI participants randomly selected to attend four 2-hour peer-led intervention groups on drug awareness, stress management, AIDS, risk reduction for sexual behavior.	3-month follow-up. Over 80% of the sample (both groups) maintained their crack cocaine use at low-level or reduced their use. Enhanced group more likely to reduce risk. Condom use in both groups decreased. Men in EI more likely to reduce crack use than SI men. No difference between women in two groups.
Deren et al. (1993)	POC/ Women (African American/ Latino)	Women were randomly assigned to two groups. Group 1: a single group session providing AIDS education and testing/risk reduction referral information. Group 2: three group session, covering the above plus condom use/needle-cleaning and negotiation skills.	Women in both interventions showed significant decrease in the average monthly number of unprotected sex acts (37 to 19) and number of partners (31 to 15) in the last 6 months; and increased percent condoms use with signal partner (18% to 43%) and with multiple partners (43% to 64%) at 6 month follow-up.
McCusker et al. (1992)▼	In drug tx	Massachusetts. 567 clients in a 21-day inpatient drug detoxification program. 67% male, 81% white. Blocked randomization. Group 1: standard AIDS education program typically provided in treatment settings, consisted of two 1-hour group sessions given early or late in tx involving video, lectures, homework, discussion, and demonstrations of condom use and of cleaning drug equipment. Group 2: enhanced intervention, six 1-hour group sessions and a 30 min individual health education consultation that focused on personal susceptibility, situational analysis and skills-building.	Authors disappointed in results. Reduction in risky drug use reported by all groups. Only significant result: enhanced group reported significantly greater reduction in injection frequency than did group 1.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Community-Level			
Jamner et al (1997)▼		AIDS Community Demonstration Project in Long Beach California. 3081 IDU who were sexually active in the past 30 days or who had shared injection equipment in the past 60 days. Peer volunteers distributed fliers featuring role-model stories targeted to the population's stage of change. Fliers were packaged with bleach kits, condoms, or both. The intervention was designed to influence behavior through the dissemination of information, the development of behavioral skills and the positive reinforcement of progress toward the consistent use of condoms and bleach. (transtheoretical model of behavior change)	Repeated cross-sectional sampling with matched intervention and comparison communities. Compared with injecting drug users in the comparison area, IDUs in the intervention area showed a significant increase in condom use with other partners. Subjects with recent project exposure had higher stage-of-change scores for using condoms with main and other partners and for cleaning injection equipment with bleach.
Rietmeijer et al. (1996) ♦	66% of study POC (African American and Latino)	AIDS Community Demonstration Project in Denver. N=1997 IDUs interviewed (89% male). Volunteers discussed and distributed intervention kits with small-media behavior intervention materials, role model stories, bleach kits and condoms to 890 individuals in high-risk population in Denver on a monthly basis over a 2.5 year period. Workers received training on basic HIV/AIDS education, role-playing interactions, methods of street approach and non-threatening conversation, and methods of dealing with individuals who refuse materials.	Proportion reporting consistent bleach use to clean needles increased significantly from baseline (20%) to early (16%) to full implementation (29%) in the intervention city; but decreased from 22% at baseline to 12% at early and full implementation in the comparison city. Condom use during vaginal intercourse with occasional partner increased significantly from 2% at baseline to 7% at early implementation and to 24% at full implementation of the intervention city and decreased from 12% to 10% in comparison city. No change on condom use with steady partner.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Street and Community-Level			
Latkin et al. (1998) □	POC (African- American)	Baltimore, Maryland. 36 peer leaders trained to promote prevention among contacts within and beyond sex and drug networks. Peer leaders participated in 10-session training groups were administered pretest and post-test surveys. Survey data also collected from 78 of the leaders' risk network members. Peer leaders had 2165 HIV prevention interactions, of which 84% were with active drug users.	Peer leaders reported a significant increase in condom use and cleaning used needles with bleach. The leaders' risk network members, compared with controls, were significantly more likely to report greater needle hygiene.
Vogt et al. (1998) †		Needle exchange (NEP), drug treatment referral system and methadone clinic, and peer-educator program to reach IDU who do not come to the exchange. <u>Comment:</u> Countless other studies show effectiveness of NEPs through studies of seroprevalence (Des Jarlais et al. 1995; Hurley et al. 1997)	Rates of HIV among IDUs have dropped from 5% in 1989 to 1.1% in 1994-96. Also, 74% of NEP clients reported no sharing of needles in the last 30 days, and 44% of those who did share reported always cleaning needles with bleach.
Coyle SL et al. (1998) □		Review of 36 published studies of outreach-based HIV risk reduction interventions for out-of-tx IDUs. Reports intervention effect on HIV-related behaviors or HIV seroincidence. Most from National AIDS Demonstration Research (NADR) or Cooperative Agreement for AIDS Community-based Outreach/Intervention Research Program—both models used a standard outreach with C&T and enhanced outreach with follow-up of counseling, role-playing, etc.). 2/3 of interventions were street-based outreach followed by office-based HIV C&T.	Most results are pre-post, no controls. Consistency of results across studies. IDUs regularly reported follow-up reductions in 5 major risk behaviors: stopping injecting, reducing frequency of injecting, reducing reuse of syringes, reducing reuse of other equipment, reducing crack use. Studies also show significant effects in 3 protective behaviors: more frequent needle disinfecting, entry into drug tx, and increases in condom use.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Siegal et al. (1995) ♦ ▼	75% of study POC (African American)	NADR site. 907 participants (74% male) assigned to one of two types of standard or enhanced intervention. Standard: a one-hour session (in the field office) which the counselor-educator provided details on HIV disease and modes of transmission and an instructional session which was followed by a videotape of role plays illustrating proper condom use and needle cleaning. Bleach and condoms provided. Enhanced: added to the standard intervention three one-to two-hour sessions on the pathology of HIV disease, drug addiction and safer sex. These were delivered over a one-month period in group sessions of 3-5 people. All participants received voluntary and confidential HIV counseling/testing as well as knowledge of negative results.	Follow-ups 5 to 9 months after baseline. Both interventions appeared to improve needle practices. The enhanced intervention showed more effectiveness in helping those with unsafe practices to become more safe, but did not appear to be more effective at helping those practicing safer needle practices maintain those practices. In multivariate analysis, subjects in enhanced more likely to change from unsafe to safe needle use. Regardless of intervention track, daily injectors less likely to adopt safer injecting practices than weekly or occasional injectors.
Wiebel WW et al. (1996)	POC	NADR site. Monitored trends in HIV risk behaviors and seroconversion among out-of-treatment IDUs receiving street-based outreach in Chicago. Began 1988, followed 641 HIV- IDUs for 4 years. Intervention guided by Indigenous Leader Outreach Model. Ex-addicts delivered HIV prevention services targeting IDU social networks in community settings. Collected baseline and 6 waves of follow-up interview data. Subjects came from 3 low-income neighborhoods: African-Am, ethnically mixed, and Puerto Rican.	Observed HIV incidence decreased, from 8.4 to 2.4 per 100 person-years. Prevalence of drug risk behaviors (sharing needles or equipment without disinfecting) decreased, from 100% to 14%. Sex risk behavior (multiple partners, sex with an IDU, or not always using condoms) decreased, from 71% to 45%.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Intervention Combination			
Tross et al. (1993, 1995) *	Women	658 Female sex partners of IDU residing in a high use housing project. Peer outreach/media distribution of flyers containing risk reduction strategies of actual peer models occurring in 2 randomly selected housing projects. Two non-intervention housing projects provided a comparison sample.	At follow-up, there was no change in condoms use or intention to use condoms in the comparison sample, while the intervention sample showed increased percentage always using condoms (18% to 30%) and decrease percentage never using condoms (46% to 27%).
Powers et al. (1990) *	Women	Female IDU and female sex partners of IDUs contract via street outreach were reached individually (4, 724) or in groups (7,829). The intervention was to study the 'early' and 'late' outreach efforts were compared, looking at reports of participants in 'safer sex workshops.' Other outreach efforts included provision of condoms and needles, referrals, group and individual counseling and client advocacy.	In early workshops, 15% reported regularly or always using condoms; in later workshops, this increased to 50% (no statistical analysis).
Kipke et al. (1998) †	Youth 24 and under	Needle exchange targeting young IDUs, which contains, art programming, peer-support groups, HIV testing and case management (largest youth NEP in the US).	Over 70% of clients reported no needle-sharing in the last 30 days, and young people who used the NEP on a regular basis were less likely to share needles.
Nyamathi et al. (1994) *♦	IDU/POC/ Homeless (Latinas)	213 participated in the study. Intervention group: 2 hour AIDS education, which included how to use a condom, problem solving techniques to enhance self-esteem. Control: HIV counseling and testing Testing video received by both	2 week follow-up. Both groups had change in risk (injection drug use, non-injection drug use, and sexual activity with multiple partners). Could be due to testing.

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Harris et al. (1998)	POC/Women (African-Am)	204 methadone-dependent, African-American women randomized into experimental and control groups. Experimental group participated in peer counseling and leadership training program over an 8-week period, followed by 8 weeks of reinforcement. Program designed to reduce sexual risk behavior, increase self-esteem, decrease depressive affect, and increase AIDS knowledge	Compared to controls, experimental group reported significant increase in numbers of safer sexual behaviors, showed decreases in depression, and reported engaging in more AIDS-related, community-based communication activities.
Monterroso ER et al. (2000)		CIDUS (Collaborative Injection Drug User Study), multicity study (Baltimore, NYC, Chicago, San Jose, LA, and a state women's correctional facility in CT). 3773 participants recruited and 2306 located and interviewed at follow-up (average follow-up period=7.8 months). HIV serostatus and participation in programs and behaviors that could reduce risk of HIV infection determined at each visit.	Not using previously used needles substantially protective against acquiring HIV and significantly associated with use of needle and syringe exchange programs. Reduction of injection frequency very protective against seroconversion and strongly associated with participation in drug tx programs. Cleaning needles not protective.
HIV Antibody Counseling & Testing			
Higgins et al. (1991) □		A review of 12 studies on the effects of C/T on behavior change (needle use, cleaning of needles and condoms use) of injection drug users (actual study reviews several populations).	From the 12 studies the results were: 50% of the studies showed some increase in needle hygiene; 42% showed decrease in needle or drug use; 25% showed increase in condom usage and, 17% showed decrease sexual partners.
Casadonte et al. (1990) *	POC	81 drug users tested and informed of HIV positive results.	Giving positive test results were associated in decrease in sex (60%) at a 10 week follow up and more condom and less drug use

IDU Population

Intervention Types/ Study Lead Author	Sub- population	Study Intervention	Study Outcome
Neaigus et al. (1990) ★	POC	276 IDU were reached by street educators who were ex-addicts, provided easy referral for HIV testing. No control group.	4.5 month follow-up. Drug use is last 30 day decreased, times injected decreased; 84% tested – half not return for results.
Partner Notification			
Levy JA et al. (1998) □	IDU	Chicago. 386 IDU participated. 63 (16%) tested HIV positive; 60 post-test counseled. Randomized to “self-tell” vs. “enhanced” groups.	In “self-tell” group marginal locating information given for at least 142 (50% injecting, 25% sex, 25% both). 82% of IDU in the “enhanced” group wanted the outreach worker to do the partner notification, and 70% of partners notified were done by outreach state. IDUs wanted assistance in partner notification and were cooperative.
Giesecke et al. (1991) □	IDU	Stockholm. 1989-1990. 365 infected patients (91% of those diagnosed in Sweden during the interval) named 564 needle-sharing or sexual partners.	390 located, 350 with known test results. 50 new seropositives identified.
No reviews on Mass & Other Media, Social Marketing, Hotlines, and Clearinghouse.			

Access Policy Issues

Drug Paraphernalia Laws. Decrease IDUs carrying syringes and increase sharing. Cited from CAPS, Does Needle Exchange Work? 12/98, original article Bluthenthal, et al. in press (*Journal of Drug Issues*).

Pharmacy Access. Increase drug users access to clean needles and has shown decrease in sharing needles. Cited from CAPS, Does Needle Exchange Work? 12/98, original article Groseclose et al. (1995)

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HETEROSEXUAL

Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
Individual-Level			
Padian et al. (1993) ◆	HIV+	144 HIV infected individuals and their heterosexual partners. Every six months, each member of the couple was interviewed separately by a staff member to obtain epi information and offered couple counseling. Couples were counseled together for first session on how to purchase, store and use condoms how to refrain from practicing anal sex; how to choose abstinence; and how not to enter into sexual relations with new partners.	The intervention was effective at improving safer sex behaviors, with behavior change occurring between initial enrollment and the first follow up. 85% of the couples who did not use condoms at initial enrollment did so by the most recent follow-up. 49% reported consistent condom use increased from 49% at enrollment to 88% at first follow-up. Other behavior changes were also made.
Group-Level			
1. Cohen et al. (1991) ▼	POC (mostly African-Am)	Los Angeles, California. 192 STD clinic patients most of who were African-Am. Increase familiarity and skill with condoms was a single group session (30 mins) for men and women registered at the STD clinic. The brief condom skills education session was led by a female health educator during regular clinic hours at the STD clinic.	Compared with controls, men and women exposed to the group intervention in the STD clinic waiting room were approximately half as likely to return to the clinic within the next 12 months with a new STD. This was a significant decrease in return rates. <u>Concern:</u> Setting specific?
2. Cohen et al. (1992) ▼	POC (mostly African-Am)	Los Angeles, California. 426 STD clinic patients most of who were African-Am. Small group format while patients were waiting for their STD clinic appointments. Groups were 10 to 25 people per session. Led by African American female health educator – soap opera-formatted video showing condom use as socially acceptable, a facilitated group discussion on methods of preventing STDs and promoting condom use and role playing, skill-building exercises to enhance condom negotiation with sex partner.	The rate of STD reinfection was significantly lower for men who participated in the intervention than for men who did not participate in the intervention. <u>Concerns:</u> No effect for women. Setting specific?

HETEROSEXUAL

Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
3. O'Leary et al. (1998)	POC (mostly African-Am)	659 patients, aged 17-44, at 7 public STD clinics in 3 eastern states. Mostly African-Am. Info and skill-building intervention consisted of 7 90-minute modules, derived from successful adolescent program. Control was existing counseling at clinics. Each group completed 90-minute interview of risk behaviors, etc.	Both groups showed significant risk reduction over time, but no difference between two groups. Authors suggest 90-minute interview may have enhanced subjects' motivation to be safer. Also, elements from adolescent program may not have been relevant to adults.
4. El-Bassel et al. (1992) ▼	IDU/ POC (African-Am/ Hispanic)	Bronx, New York. 62 African-American and Hispanic women who were enrolled in a large methadone maintenance program for a least 3 months. Intervention consisted of five 2-hour group session in skills building for 9 to 10 women. Group leaders were experienced female drug counselors who had received an additional 20 hours of intervention training. The first two sessions focused on HIV transmission information and prevention techniques. Session 3 was discussion and role-playing about condom use. The final two sessions were focused on assertiveness training, problem solving, and communication skills. Comparison group received on session of AIDS information routinely provided by the clinic.	Compared to the information-only group, women in the skills-building group showed an increase in frequency of condom use at 15 month follow-up. The groups did not differ significantly in number of sex partners.
5. Kelly et al. (1994) ★♦♦	African-Am women	197 women at urban primary care clinic randomly assigned to intervention or control. Intervention included four 90 min group sessions and 1 month group follow-up with 8-10 women in group with two leaders. Provided information, role plays, managing 'triggers', group problem solving and active support. Comparison group attended sessions on health topics unrelated to AIDS.	At 3-month follow-up, intervention group had increased communication and negotiation skills, decreased UVI, increased condom use. Control group showed no change. <u>Concern:</u> short follow-up

HETERC XUAL

Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
6. Schilling et al. (1991) ♦★	POC Women/ Methadone Tx	91 African-American and Hispanic women enrolled for at least 3 months in 1 of 5 clinics in a methadone maintenance program in NYC. Non-peer led skills-building groups, five 2-hour sessions offered to groups of 9-10. Topics included: HIV 101; identification of high-risk sexual practices; discussion of barriers to adopting safer sex practices; negative association with condoms; practiced condom use skills; and role-played negotiation of condom use; assertiveness; problem solving; and communication skills involving safer sex scenarios. Control group provided 1 HIV information-only session.	The skill-building intervention group showed statistically significant higher use of condoms than those in the control group at a 15-month follow-up. Participants also showed more comfort with taking and carrying condoms.
7. DiClemente et al. (1995) ♦+▼	POC/ young women	Peer mediated 128 sexually active women aged 18-29. Five 2-hour weekly group sessions. Session focused on gender, ethnic pride, knowledge of HIV risk behaviors, prevention strategies, sexual assertiveness, modeling and role playing; correct condom use; norm setting exercises and coping skills, sexual self-control, communication skills, and practicums	At 3-month follow-up. The social skills intervention was effective in increasing consistent condom use.
8. Harris et al. (1992) ★	POC/ Drug Use (African American)	Self-selected African American women from a methadone clinic participated in 8 2-hour peer HIV leadership training groups, focussing on: AIDS and human sexuality education; condom use and negotiation skills building; empowerment; an exploration of gender roles in relationships; social support; group process and diffusion techniques.	Immediately post-intervention, there was a positive change toward safer sex; consistent condom use increase for 3 to 5 of 7 sexually active women; never condom use decreased from 5 to 2 of 7 sexually active women. (pilot study...sample size small).

HETEROSEXUAL

Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
9. Shain RN et al. (1999)	Women of Color	424 Mexican-American and 193 African-American women with nonviral STDs. Randomized trial. Intervention 3 weekly small-group sessions, 3-4 hours each. 5-6 women per group and female facilitator, all of same race/ethnicity. Sessions designed to help recognize personal susceptibility, commit to changing behavior, and acquire skills. Based on AIDS Risk Reduction Model. 6 and 12 mo follow-up.	High rates of session attendance and retention in study. Rates of subsequent infection significantly lower in intervention group at both follow-ups. <u>Comment:</u> Very strong study design.
10. O'Donnell et al. (1994) and O'Donnell et al. (1998)	African Am and Hispanic males	2,004 adult males in South Bronx, New York. Tested video-based STD prevention. Random assignment to three groups: video plus discussion, video only, usual clinic services (control). Interactive session was small group format (three to eight patients) at the clinic and facilitated by an STD counselor. Two culturally sensitive videos (Let's Do Something Different for African Americans and Porque Si for Hispanics).	Men who participated in experimental groups had significantly lower rates of new STD infection than those in comparison group. No difference between video only group and video plus discussion group. Clients with multiple sex partners experienced greatest effect.
11. Malow et al. (1994) ♦	POC/ Drug use (African American – male- cocaine users)	152 African American males at in-patient tx program participated in group-level sessions. Non-peer led, held for 2 hours over 3 consecutive days, 6-8 people. 1 session on HIV knowledge/risk, demonstrated cleaning works. 2 nd session on safer sex, condoms use, condom negotiating, and skills-building exercises. Final session on review and discussion of HIV testing procedures.	47.5% of intervention group participants reported having more than one partner at three-month follow-up compared to 76% at the baseline. In the comparison group. The change from 76% at baseline to 59% at the follow was considered to be not statistically significant. Sexual risk taking decreased from 75% at baseline to 32% at follow-up.
12. Kalichman et al. (1999)	African-Am men	117 heterosexually active African-American men recruited from public clinic. Randomly assigned to either a 6-hr video-based small group motivational-skills intervention or a 6-hr video-based HIV education comparison group.	Men in motivational-skills group decreased rate of unprotected vaginal intercourse and used more condoms at 3 months. Both groups showed increased condom use at 6-month follow-up.

HETERC XUAL

Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
13. Susser et al. (1998)	Homeless men	97 men (of 116 eligible) from a psychiatric program at a homeless shelter participated in a randomized clinical trial. Most were African-American with a chronic psychotic disorder and substance use disorder. Two arms: 15-session group intervention or 2-session control intervention. Observed for 18 months.	For 59 participants who were sexually active before the trial, experimental group's mean score on sexual risk index was 3 times lower than control group's at 6 months and 2 times lower at 18 months.
14. Nyamathi et al. (1993) *	Women drug using/ homeless	858 women in homeless shelter participated. Control group receive 1 hour AIDS education and testing small group. The test group received a 2 hour program with testing individualized, behavior practices, coping, self-esteem. Video in both groups.	At 2 weeks post test, both conditions associated with reduction risk; no effects of specialized intervention. <u>Concern:</u> Very short follow-up.
15. Rhodes et al. (1992) *	Women (Sex partners of IDUs)	69 women recruited through street outreach participated in 3 90-min group sessions heal on consecutive days then a fourth session one week later and underwent HIV C/T. Sessions focused on AIDS education, condom use, needle cleaning, negotiation, problem-solving skills building; referrals; and post-intervention weekly support groups.	At immediate post-intervention, 91% reported having made positive changes to reduce AIDS risk and 68% of women who did not use condoms before entering intervention. (no statistical analysis)
16. Schilling et al. (1994) *	Drug Use/ Women/ Jail	159 Drug-abusing female offenders, approaching release from a 3-12 month sentence, were recruited from Rikers Island. Women were randomly assigned to (1) 8 group session conducted in prison and 8 individual session in the community post-release, focussing on AIDS information; condom use; needle-cleaning; and negotiation skills building and social support; or (2) an information-only	At follow-up, there was a trend for intervention participants to report greater condom use improvements.

HETEROSEXUAL

Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
17. Eldridge GD et al. (1997)	Drug-using women	117 drug-using women court-ordered into inpatient drug tx. Compared effectiveness of an educational intervention and a behavioral skills training intervention at reducing sexual risk. Both groups reported high rates of sexual risk prior to intervention.	At 2-month follow-up, women in skills training groups showed improvement in communication skills, condom application skill, and condom use. Both groups showed decreased drug use and drug-related high-risk sex activity. <u>Concern:</u> short follow-up
18. Hobfoll et al. (1994) ★◆	Pregnant Women	206 participants, who were single pregnant women, attended four 90-120 min. group sessions of 2-8 women, taped segments of assertiveness, negotiation, planning, and AIDS prevention skills including role plays, cognitive rehearsal, formulate health action plan.	6 mo. Follow-up improvement in condom use for vaginal sex, condom and spermicide acquisitions for intervention and not for control. <u>Concern:</u> Applicability to non-pregnant persons.
19. Baker S et al. (1999) Personal communication	Women	Choices Project. Women randomly assigned to Relapse Prevention intervention (experiment) or health education and social support intervention (control). Both interventions 16-session, 2-hour weekly groups.	Both groups reduced number of risky sexual acts at 4 months and change is sustained at 12 months. No difference between groups. Both groups also increased and maintained safer sex negotiation skills.
20. Wenger NS et al. (1992) ▼	College students	435 university students at outpatient student health clinic. Consisted of a multimedia presentation in a single 1-hour small-group session. Led by physicians familiar with HIV counseling. The session began with an 11 min video, 15 min scripted lecture (AIDS 101, routes of transmission, and safer sex behaviors, obstacles to using condoms, communication with sex partners, and the role of drugs and alcohol in promoting unsafe sex behaviors). Following the lecture, participants engaged in 15 minutes of role-play and 15 minutes group discussion. Students randomly assigned to get HIV testing.	After 6 months, heterosexual university student who received education about HIV infection plus HIV testing were more likely compared with students in the control group to increase communication with their sexual partners about the risk of HIV infection. No difference in condom use or number of sexual partners. <u>Concern:</u> Applicability of results to other (non-college, high-risk) populations.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
21. Sikkema et al. (1995) ♦	College women	43 heterosexual college women participated in four 75 to 90-min. session held over a one-month period with groups of seven to 10 participants. Female doctoral students served as group mediators. The intervention covered topics such as risk behavior education, behavioral self-management, assertiveness training, decision making, safer sex negotiation, condom use and maintenance of risk-reduction behavior. The control group received one 90-min. session covering the same topics but using a didactic education approach.	The intervention was effective at improving one key determinant of sexual risk behavior: sexual assertiveness and communication skills. The skill-building participants showed greater improvement from baseline to the immediate follow up in overall assertiveness skill, in the sum of four components of skill and in two of the four components: acknowledgment of partners' request for sex and suggestion of alternative lower-risk behavior. <u>Concern:</u> Applicability of results to other (non-college, high-risk) populations.
22. O'Leary et al. (1996)	College students	Low-intensity, institutional safer sex campaign at NJ college. Mailed sexual behavior surveys to 1 st year students at intervention and control campuses at beginning and end of year.	Men at intervention campus (vs. control) significantly reduced risky sexual encounters. Women did not. Women at intervention campus (vs. control) showed reduced self-efficacy to perform safe sex.
23. Stanton et al. (1996) ▼	African-Am youth	Public Housing developments/rural campsites. 383 African-American youth, 9 to 15 years of age, in peer groups. 7 weekly sessions (1 - ½ hour each) and one day-long session. Each session led by a pair of interventionists, recruited from the community, most of whom were African-American. Group sessions included communication and negotiating skills, value clarification, goal setting and peer norms. Small-group discussions, lectures, videos etc. In session 7 the group developed community projects with associated intervention messages. The final session was a graduation ceremony.	Condom use in the short term (6 month after intervention) showed significant improvement for intervention youth compared with control youth. Long-term follow-up (2 years) showed that intervention youth were less likely than control youth to adopt a risk behavior, though they were not less likely to experiment with a risk behavior. <u>Concern:</u> Condom use difference disappeared at 12-month follow-up.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
24. St Lawrence et al. (1996) ★◆	POC/youth (African American)	246 participated in eight 90-120 min weekly meetings on behavioral skills, values, condom use skills, and refusal skill. Control group received 2 hour of education.	One year follow-up 31% in control initiated sex compared with 12% in treatment group both males and females lower rates of unprotected sex, control did not. (Social Cognitive)
25. St Lawrence et al. (1995) ▼	POC/ Youth (African- Am)	Public health clinic serving low-income families in a mid-size southern US city. 146 inner-city youth ages 14-18. Intervention was 8 group sessions (1½ to 2 hours each) of 5 to 15 participants. Group session were co-led by trained facilitators. The group members used role-playing techniques and practiced skills-building activities in smaller groups of two to three persons. In session 1- HIV/AIDS education. Session 2: peer pressure and sexual decision making. Session 3: communication and assertiveness skills-building activities. During session 7 an HIV positive youth met with the group. The final session: discussion on the most beneficial components of the intervention and how they increased self-efficacy.	Male and female adolescents who received the intervention increased condom use significantly. The males in the group also lowered their rates of unprotected intercourse to a greater extent than did males in the information-only intervention. The females who received skills-training, compared with those who received information only, decreased the frequency of unprotected intercourse. Thus, the skills training intervention was more successful both in lowering risky behaviors and in sustaining safe alternatives such as condom use among youth who remained sexually active.
26. Jemmott et al. (1992) ★◆▼	POC/Youth (African American – male)	157 participated in 5 hour intervention based on theory of reasoned actions. Intervention provided information, video, games, exercises, and skills building. Other group was provided different subject matter presentation.	3 mo. follow-up, fewer sexual partners in intervention group, more condom use and less anal intercourse.
27. Rotheram et al. (1991) ★◆†	POC/ Youth (runaways)	Non-random control 197 runaways. Small group sessions 90-120 min., 4 days/week. Each up to 30 sessions at least 3 private session, develop soap opera dramas, review videos, skills coping.	3 and 6 month follow-up. Increased number of sessions associated with increased condom use, and decreased risk behaviors. An update of the intervention in 1997 CDC compendium shows similar results.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
28. Walter et al. (1993) ★♦	POC/ Youth	School-based program with two intervention schools and two comparison schools, 1316 students. Six 1-hour lessons on AIDS facts, risk appraisal, personal values, norm change, role play, negotiating skills, and how to use condoms.	Three month follow-up and change scores on knowledge, benefits, norms, self-efficacy and risk; unavailable for follow-up were riskier at baseline, modest effects on behavior. <u>Concern:</u> Setting specific?
29. Howard et al. (1990) ★	POC/ Youth	Eight graders (536) recruited through medical records. Intervention was peer-led 5 sessions, emphasis on postponing sexual involvement, discussing peer pressures, skill practice to resist pressure.	18 month follow-up fewer students initiated sex in intervention group. <u>Concern:</u> Emphasis on postponing sex.
30. Magura et al. (1994) ▼	Young POC (African-Am/Hispanic) Jail/ drug users	NYC DOC Adolescent Reception and Detention Center. 157 youths aged 16-19, most were African-American or Hispanic. 4 1-hour small-group sessions of eight led by male counselor which focused on health education issues relevant to male adolescent drug users, with an emphasis on HIV/AIDS. Group activities included role-play and rehearsal techniques.	Youth in the intervention were more likely to use condoms during vaginal, oral or anal sex, had fewer high-risk sex partners, and had more favorable attitudes toward condoms than youth not in the intervention.
31. Levy et al. (1997) ★	Youth	School-based program with 15 school districts randomly assigned to 3 conditions a) parent interactive; b) parent non-interactive and c) wait list. Intervention was lecture, small group discussion, skills building to: resist social pressures; obtain preventive practices, role play, practice, homework. 10 session provided to 7 th graders and 5 sessions provided to the 8 th graders.	Intervention groups use of condoms and foam from 14% to 24%. Had sex less often. No difference in use of condoms alone. <u>Concern:</u> Setting specific?

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
32. Kirby et al. (1991) ♦♦▼	Youth	School-based program conducted over 15 classroom periods, with teach-led discussion and exercises where teach and classroom peers modeled desirable behaviors. 23 classes in ten urban and rural school districts.	Intervention group had prolonged first onset of intercourse than control group. After 18 months, 29% of the intervention group had initiated intercourse compared with 38% of the control group. Outcomes regarding unprotected sex refer generally to birth control, not specifically to condoms. <u>Concerns:</u> Small effect, if any, for high-risk sexually active youths. Setting specific?
33. Main et al. (1994) ♦♦▼	Youth	School-based program conducted over 15 sessions (40 hours). Program consist of 3 HIV knowledge sessions, 2 normative determinates of risky behavior, one on teen vulnerability and eight on development skills to identify and manage risking situations.	AT 6-month follow-up, sexually active students reported significantly fewer partners and greater frequency of condom use. <u>Concern:</u> Setting specific?
34. Basen-Engquist et al. (2001)	Youth	School-based Safer Choices program, a multicomponent, behavioral-theory-based HIV, STD, and pregnancy prevention program. 20 urban high schools randomized into intervention and control	At 19 months, decreased frequency of sex without a condom. At 31 months, less sexual intercourse without a condom with fewer partners.. Program did not influence prevalence of recent sexual intercourse. Cost-effectiveness study showed that Safer Choices is a cost saving program under a wide range of estimates (Wang LY et al.). <u>Concern:</u> Setting specific?
35. Gillmore MR et al. (1997)	Youth	Total of 396 high-risk youth aged 14-19. Three interventions: comic book, videotape, and group skill-based training.	All had modest pre-post effects, but there were few differences between interventions at 3 and 6 month follow-up.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
Jemmott et al. (1998)	African-Am Youth	Randomized controlled trial with 3-, 6-, and 12-month follow-up. 659 male and female African-American 6 th and 7 th graders. 8 1-hour modules, adult facilitators or peer co-facilitators. Abstinence intervention stressed delaying intercourse or reducing frequency; safer sex intervention stressed condom use; control intervention concerned health issues unrelated to sexual behavior.	Abstinence: less likely to report sex at 3 months, but not at 6 or 12 months. Safer-sex: more consistent condom use than control at 3 months and higher frequency of condom use at all follow-ups. Among youth sexually experienced at baseline, safer-sex intervention reported less sex at 6 months and 12 months than other two groups and less unprotected sex at all follow-ups than control. No differences in intervention effects with adult facilitators compared with peer co-facilitators.
National Institute of Mental Health (NIMH) Multisite HIV Prevention Trial Group (1998)	POC	Project Light. Randomized, controlled trial with 3 high-risk populations at 37 inner-city, community-based clinics at 7 US sites. 1855 control and 1851 intervention participants, mostly African-American or Hispanic. Experimental condition: Small-group (5-15), twice weekly 7 session program, 90-120 minutes per session. Separate male and female groups. Co-led by a male and a female facilitator. Control condition: 1-hour AIDS education session that included videotape and Q&A period.	Both groups decreased frequency of unprotected sex at follow-up. Compared to controls, intervention group reported fewer unprotected sexual acts, had higher levels of condom use, and were more likely to use condoms consistently over a 12-month follow-up period. In intervention group, more sessions attended associated with greater behavior change. No difference in overall STD reinfection rate. Among men recruited from STD clinics, lower gonorrhea incidence at follow-up.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
Community-Level			
Vincent et al. (1989) ★	POC/ Youth	Intervention to reduce adolescent pregnancies. Three-hour courses for teachers. Sex education in all grades. Training for clergy, church leaders and parents. Mass media speakers.	2 year follow-up. Pregnancy rates decreased by half in target county only. <u>Concern:</u> Applicability.
Sikkema et al. (2000)	Low-income women	690 low-income women living in 18 housing developments. Community-level intervention in 5 US cities. HIV risk reduction workshops and community prevention events implemented by women who were popular opinion leaders.	At 12-month follow-up, proportion of women who had any UI decreased and percentage of protected sex acts increased in intervention group. Little behavior change in control group.
Tross S et al. (1993)	Female sex partners (FSPs) of IDU	658 FSPs in high drug-use housing project in NYC randomly assigned to intervention or control. Intervention was peer outreach and media distribution program.	Significant increase in percentage of intervention group always using condoms and decrease in percentage never using condoms. No change in control group. <u>Comment:</u> Information from abstract only so few details available.
Lauby JL et al. (2000)	Women (mostly African-Am)	Low-income, primarily AA women in 4 urban communities. Pre-post surveys in matched intervention and comparison communities. Targeted sexually active. Activities: development and distribution of prevention materials, mobilization of peer network of community volunteers, delivery of prevention messages by trained outreach specialists through individual contacts and small-group activities. Role model stories. A total of 225-240 women interviewed in each intervention and comparison community in each wave of survey.	After 2 years, significant increase (11 pct pts) in rates of talking with main partner about condoms, also sig increase (13 pct pts) in proportion who had tried to get main partners to use condoms. Almost significant (p=054) decrease (9 pct pts) in never using condoms. Effects stronger for women who reported exposure to intervention. No intervention effects for condom use during most recent sex or for consistent condom use, but both groups increased over time. Trends for condom use for other partners similar but not significant.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
The CDC AIDS Community Demonstration Projects Research Group (1999)	IDUs, their female sex partners, sex workers, NGI MSM, high- risk youth, residents of areas with high STD rates	Role model stories distributed with condoms and bleach by community members who encouraged behavior change. Quasi-experimental design. Over 3 years, 15,205 interviews conducted with 10 intervention and comparison community pairs. Outcomes measured on stage-of-change scale.	By end of intervention, 54% of persons interviewed in intervention communities had been exposed to materials in past 3 months. Consistent condom use with main and non-main partners, esp. for VI, and increased condom carrying, greater in intervention communities. At individual level, respondents recently exposed to intervention more likely to carry condoms and to have higher stage-of-change scores for condom and bleach use.
Sellers et al. (1994)*◆	POC/ Youth (Latinos)	18 month community based program promotes and distributes condoms, workshops, group discussion, presentations, conversing, poster, and newsletters.	Purpose of study to see if condom distribution increases sexual activity. 18 month follow-up. Males in intervention city less likely to become sexually active, girls less likely to report multiple partners. <u>Concern:</u> Applicability.
Street and Community-Level			
Fritz et al. (1992) *	Sex workers	Street outreach targeted by community outreach programs in Chicago (92 female sex workers).	At 2-month follow-up, women sex workers “increased their condom use” and “reduced number of sex partners”. (From compendium, no statistical analysis)
Intervention Combination			
Nyamathi et al. (1994) *	POC (Latinas)/ Homeless and/or drug addicted	213 participated in the study. Intervention group: 2 hour AIDS education, which included how to use a condom, problem solving techniques to enhance self-esteem. Control: HIV counseling and testing Testing video received by both.	2 week follow-up. Both groups hand change in risk. Could be due to testing.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
HIV Antibody Counseling & Testing			
Higgins et al. (1991) □		A review of 10 studies on the effects of C/T on behavior change (condom use, reduction of sexual partners) of heterosexuals (actual study reviews several populations).	Of the studies: 80% showed increase in condom use; 30% showed increase in safer sex (undefined) and 1% showed decrease in sexual partners (Note: must were measuring for condom usage – 1% may not be reflective of real change).
Kamb et al. (1998) ▼		Project Respect. Five publicly funded STD clinics located in US inner cities (Baltimore, Denver, Long Beach, Newark and San Francisco). 5758 heterosexual HIV-negative men and women who initially came to the clinics for STD diagnosis and treatment. Three face-to-face interventions: enhanced counseling (3-hours interactive sessions), brief counseling (2 40-minutes interactive session) and didactic message (personalized 10-minutes informational messages about HIV/STD prevention).	3 and 6-month follow-up visits, any condom use and consistent condom use were significantly higher among participants in both enhanced and brief counseling compared with control. Through the 6-month interval, 30% fewer participants had new STDs compared with control. Through 12 months, 20% fewer participants in each counseling intervention had new STD compared with didactic group. Comment: Supported by Branson et al. (1998) <i>Sex Transm Dis</i> 25: 553-559.
Corby et al. (1990) ★	Sex workers	64 sex workers were randomly selected into four groups. Group 1: HIV counseling/testing. Group 2: 15-min. AIDS prevention program with rehearsal of condom use. Group 3: both 1 & 2. Group 4: No intervention	At 1 month follow-up, women in group 3 showed significant increase in condom use during vaginal intercourse with customers. Women in group 1 reported a significant decrease in proportion of condom use during oral sex with customers.
Bevier et al. (1991) ★	Women (STD clients)	1016 total STD clinic patients received one-session of HIV risk behavior counseling. Total percentage of women unknown.	At 6 month follow-up, women significantly reduced their total number of partners from 5.9 to 4.3 in a 6 month period. Condom use 'increased slightly', but sex partners of IDs reported condom use only 10% of the time.

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Intervention Types/ Study Lead Author	Sub-population	Study Intervention	Study Outcome and Comments/Concerns
Partner Notification			
Toomey et al. (1998) <input type="checkbox"/>		New Jersey and Florida. 8 partners reported per case, one located per case.	25% previously positive. 75% of the remainder were tested. 22% positive. New positive partners per original case: 0.1. Cost: \$250/index patient; \$427 partner notified; \$2,200 new infection identified.
Jordan et al. (1998) <input type="checkbox"/>		Los Angeles. 22 of 22 women, 5 of 8 heterosexual men and 6 of the 44 MSM interviewed were able to provide locating information on all of their enumerated/reported partners. Intervention divided MSM into two focus groups. Group 1 was asked: Who do you know that's HIV positive and still practicing unsafe sex? Group 2 was asked: Who do you know that's HIV positive but not in treatment?	13 of the 14 MSM in group 1 were able to identify 30 person they felt were still practicing unsafe sex; 17 of the 30 tested HIV positive and 9 were unaware of their status. Group 2 identified 15 person they felt were HIV positive. 11 were found to be HIV-positive and 8 were unaware of their status.
Pavia et al (1998) <input type="checkbox"/>		Utah. All persons reported in state over 2 years (308) 79% cooperated with 890 named partners with 70% located.	Of those located 34% were previously positive. Of the remaining 2763 tested, 14% newly identified as infected. IDU, women and confidential (vs. anonymous) testers were more likely to cooperate and reported more partners. Cost: about \$3,000 per new infection identified.
Landis (1992) <input type="checkbox"/>		North Carolina. Three local health departments. 162 participated, 54% declined and 46% agreed. 39 assigned to provider referral, 35 to patient referral.	In provider referral, 70 of 157 successfully notified; patient referral, 10 of 153 notified. 23% of partners notified and tested were positive.
Rutherford et al. (1991) <input type="checkbox"/>		San Francisco. 51 interviewed AIDS patients named 135 opposite-sex partners.	44% of partners located and interviewed, 25% tested, 5% HIV infected. Cost: \$454 per partner notified. \$2,203 per positive identified.
No reviews on Mass & Other Media, Social Marketing, Hotlines, and Clearinghouse.			

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Notes from general review articles

Coryb and Jamner, UCSF website, *HIV Prevention Interventions: What Works and What Doesn't* (1996)

- While any intervention can be delivered either by a non-peer professional or by a trained peer, available data suggest that peer-based interventions are superior for achieving behavior change.
- All forms of HIV prevention will be more effective if they are culturally, socially, and linguistically appropriate to the populations they are designed to serve.
- **CTRPN**: tends to reduce risk behaviors in people who test positive, especially heterosexual discordant couples. Little evidence of behavior change in negatives. Cost effective, especially in high-prevalence populations.
- **Individual-level interventions**: Individual counseling may be most effective when delivered by trained peers over multiple occasions. Street outreach effective at reaching at-risk individuals who may otherwise be unlikely to access HIV prevention services (e.g., IDUs, commercial sex workers). May have greatest impact on sex- and drug-related behavior when delivered by trained peers and when accompanied by provision of appropriate prevention material (e.g., condoms, bleach kits). NX effectively reduce frequency of sharing needles and syringes and may improve needle hygiene. Impact on sexual behavior less clear, though no increase in sexual behavior associated with NX.
- **Group-level interventions**: Have been shown effective in promoting safer sex among gay and bisexual men, but most research is for white, college educated, and self-identified older gay men. Small-group counseling for IDUs receiving drug tx not adequately evaluated. In general, easier to change IDUs needle-risk behavior than sexual-risk behavior. School-based programs reviewed.
- **Community-level interventions and social marketing**: Social marketing studies from Switzerland and France showed behavior change. In California, fotonovelas and radionovelas to get info to Spanish-speaking migrant farm workers successful in changing KAB of prostitutes. CDC's AIDS Community Demonstration Projects developed small media pieces distributed via peer volunteer networks to IDUs and female sex partners, NGI men, female sex workers, and high-risk youth. Able to access members of hard-to-reach pops and saw sexual and drug-risk behavior change.

NOTES:

- I also didn't review the literature from other countries, particularly developing countries. The context seemed so different from what we face and several review articles stated that the impact of prevention interventions are less strong in developed countries because of the resources we have and where we are in the epidemic.
- Because the effectiveness and importance of NX, drug treatment, and CTRPN are well-established, I haven't reviewed that literature (that's already been done in previous years). I recommend that they be part of the plan so that Public Health can continue spending money on them with these funds and with internal omnibus dollars.

Heterosexual Priority Sub-populations

1. **Female sex partners of high-risk males (HIV+, bisexual, IDU) (higher priority for African-American, Latino, Native American, and low-income women).**
2. **Men and women with STDs, especially African American, Latino, Native American, and low-income women and young women (under 25 years old).**

General results from review articles

Rotheram-Borus, Cantwell and Newman (2000) "HIV Prevention programs with heterosexuals."

Three HIV prevention strategies have been successful with heterosexuals: (1) programs based on social cognitive theory that focus on behavioral skill and shifts in social norms, (2) treatment of STDs; and (3) HIV testing and counseling programs.

Social cognitive programs most successful in four settings: STD clinics, street-based interventions for substance users, mental health clinics, and a community trial implemented in international settings. Interventions work with highest risk groups, similar efficacy across ethnic, gender, and age groups. Have been least successful at reducing sexual risk in street outreach programs with IDUs. Needle sharing risks have declined but not sexual risk. Almost all have been face-to-face interventions in an individual or small group setting.

C & T effective at reducing sexual risk acts among HIV-positive adults, especially those in serodiscordant relationships.

Peersman and Levy, (1998) "Focus and effectiveness of HIV-prevention efforts for young people"

Effective programs had narrow focus on reducing sexual risk-taking behaviors. Basic facts about the risks of and ways to avoid unprotected intercourse were provided through active learning methods aimed at personalizing the information, rather than didactic instructions. Success may be related to focus on understanding social and/or media influences on sexual behaviors, and strengthening group norms against unprotected sex through reinforcement of clear values. Ineffective programs tended to teach young people skills to make their own decision within a range of values. Though effective programs included modeling and practice of communication or negotiation skills, there were significant variations in quality and amount of time devoted to this and it didn't distinguish them from ineffective programs. Another inconclusive factor is length of intervention—but components of effective interventions can't be provided in programs lasting only a couple of hours.

Integrating pregnancy and STD prevention has benefits as long as doesn't become too unfocused. An important component, especially in programs for disadvantaged young people, is provision of access to resources and/or services to address basic needs.

Ehrhardt and Exner (2000), "Prevention of sexual risk behavior for HIV infections with women."

Relational skills-based interventions of longer duration (5 or more sessions) appear to have the most potential for reducing the risk of HIV infection in women, particularly when targeted toward women. Brief informational interventions, in the absence of a skills component, show limited effectiveness. The sole study that evaluated the effects of a brief group condom skills intervention failed to find significant effects on behavior.

Office of Technological Assessment (1995), The Effectiveness of AIDS Prevention Efforts

Multiple counseling and skills sessions targeted at female injecting drug users, female sexual partners of injecting drug users, and inner-city or low-income women seem to provide a benefit in terms of increased condom use. A controlled study of a program of peer outreach combined with distribution of written material containing risk-reduction strategies increased condom use among female sexual partners of injecting drug users living in public housing projects.

Pinkerton, Cecil, and Holtgrave (1998), HIV/STD Prevention Interventions for Adolescents: Cost-Effectiveness Considerations.

Individual-focused interventions with adolescents typically employ a cognitive-behavioral paradigm to teach and encourage the use of cognitive, social, and self-management skills to reduce performance of unsafe sexual practices, combined with risk sensitization exercises to combat perceptions of personal invulnerability. Such interventions are often conducted within a small-group setting. This approach has been shown to be successful in changing the sexual risk behaviors of inner-city African American adolescent males, runaway and homeless adolescents, and adolescents in clinical settings.

Based on comparisons with spending in other areas of medical care/disease prevention, Pinkerton and Holdgrave (in press) have estimated that an intervention that prevents an HIV infection for less than about \$1.2 million should be considered cost-effective by current standards. Most HIV sexual risk reduction interventions evaluated to date are cost-effective by this standard, and many, in fact, are cost-saving.

In contrast to targeted interventions with high-risk adolescent populations, the potential of many school-based programs to have a substantial impact on reducing high-risk behaviors is limited by the relatively low average risk among most adolescent populations, the diluted nature of the HIV/STD prevention messages that many of these programs convey, and because the content of many such programs is largely educational, with a small or non-existent behavioral skills training component.

Ickovics J, Ickovics JR, and Yoshikawa H (1998) Interventions to reduce heterosexual HIV risk for women: Current perspectives/future directions. 12th World AIDS Conference, Geneva.

Small group and community-wide interventions showed evidence of effectiveness, whereas those focused on the individual were less likely to be effective. Programs targeting commercial sex workers and US African American/Latina women were likely to be effective, whereas those targeting IDUs, partners of IDUs, college students, and men and women together were less likely to be effective.

Wren PA, Jans NK, et al. (1997) Preventing the spread of AIDS in youth: principles of practice from 11 diverse projects. *Journal of Adolescent Health* 21 (5): 309-17.

Review of 11 projects identified 3 elements of effective interventions: involvement of peer educators, recognition of the role of adults (e.g., parents, teachers), and use of structured settings to gain access to the target population (e.g., schools, clubs).

NOTES:

- There is a lot of literature on school-based programs. In the interest of time, I stopped reviewing them because I doubted that we would fund a school-based program. If the workgroup disagrees, I can go back and get those articles.

IDUs—notes from review articles

Office of Technological Assessment (1995), The Effectiveness of AIDS Prevention Efforts
Successful drug detoxification and treatment are the best methods of AIDS prevention among injecting drug users. Several needle exchange programs (NX) in the US have been evaluated. In every published study, no evidence found that the programs result in any increase in illicit drug use. A GAO study found a decrease in drug use associated with implementation of a needle exchange. There is evidence that outreach programs and needle exchange programs uncover demand for drug detoxification and treatment and were a significant source of referrals to these programs. Several studies provide evidence that access to sterile injection needles has a beneficial effect on the drug-related behavior that puts individuals at risk for contracting HIV.

Interventions for HIV+ People--literature notes

Note: Several studies show that people significantly reduce their risk upon learning that they are HIV+. I didn't review that literature here, but it does support the need for counseling and testing.

Rotheram-Borus MJ, Lee MB, Murphy DA et al. (2001) Efficacy of a prevention intervention for youths living with HIV. *American Journal of Public Health* 91: 400-5.

310 youths, 72% male (mostly MSM) and 28% female, aged 13-24, 27% African-Am and 37% Latino. Study conducted at 9 adolescent clinical care sites in 4 cities. Assigned by small cohort to a 2-module ("Stay Healthy" and "Act Safe") intervention with 23 sessions or to a control condition. In intervention condition, 73% attended at least 1 session. Assessment of module 1 conducted 6 months after completion. Assessment of module 2 conducted 3 months after completion. Cohorts mixed according to sex. (Detailed manual available on web at <http://chipts.ucla.edu>.) Had difficulty getting youths to attend sessions.

Outcomes: Following "Stay Healthy" module, number of positive lifestyle changes and active coping styles increased among intervention females vs. control. Social support coping increased for all intervention clients vs. controls. Following "Act Safe" module, intervention youths reported 82% fewer unprotected sexual acts, 45% fewer sexual partners, 50% fewer HIV-negative partners, and 31% less substance use than controls.

Collins C, Morin SF, Shriver MD, Coates TJ (2000) Designing Primary Prevention for People Living with HIV. *AIDS Research Institute, UCSF, Policy Monograph Series, March 2000*.

Has list of interventions largely based on presentations made at a June 1999 conference hosted by ARI at UCSF and NAPWA.

AIDS Action Committee (AAC) of Boston

- Social marketing campaign targeting negatives and positives around avoiding transmission. Started 5 years ago, posted over urinals in gay bars and sex clubs. Survey of men leaving bathrooms showed 70% unprompted recall of 2 or more messages.
- PCM program in context of social service CM for positive clients. 50-60 volunteers call about 250 clients once or twice a week to check in and do CM. Trained to do prevention counseling. 2000 other clients get a call every 3-5 months.
- Monthly meeting at local gay bar with 150-200 HIV+ gay men. Socialization and discussion of treatment and adherence issues.
- *Women Initiating New Directions* (WIND), 5-session curriculum for women clients, prevention frequently raised as an issue by clients.

Los Angeles Consortium

- *Positive Images* program, set up by 6-agency multicultural consortium. Goals: raise awareness of role of positive men and women in prevention, provide social networks to promote self-esteem and self-efficacy to practice safer sex, encourage clients to reduce risk of co-infection with STDs, promote testing. Components: telephone chat line (2 ½ hour sessions, facilitated by peer staff member, several subpopulation-specific groups) and drop-in support group.

- LA Health Dept provides *Vidas Positivas* for Latino/as. Offers PCM, peer support, social occasions. HD also uses case finding, based on targeted outreach to clinics (Oasis model).

AIDAtlanta

- Social marketing campaigns and a behavior modification program for African-American women. One program places trained volunteer educators in Internet chat rooms. Volunteers include hot button words (e.g., barebacking, drugs) in profiles to encourage others to contact them. *HIV Stops with Me*, 6-week group for positive clients emphasized personal responsibility.

Asian & Pacific Islander Wellness Center, SF

- Currently designing 8-session group intervention for API MSM. Will deal with disclosure (to family and to dates), safer sex, assumptions about status, implications of new treatments. Will be piloted as 8-session program over 8 weeks and as a weekend retreat.

Teens Linked to Care—UCLA

- Study for “Stay Healthy” and “Act Safe” modules for teens. Review of AJPH article in these notes.

[Section below on current research projects copied and pasted directly from monograph.]

MSMs and IDUs in Urban Settings

Cynthia Gomez -- University of California, San Francisco

Cynthia Gomez is involved in several research studies relevant to prevention for positives. The Seropositive Urban Men’s Study (SUMS) and the Seropositive Urban Drug Injectors Study (SUDIS) are designed to:

- Describe the sexual behavior, disclosure and drug use patterns of a sample of HIV-positive men who have sex with men (MSM) and of a sample of HIV-positive heterosexual male and female IDUs.
- Identify demographic, psychosocial and contextual factors that help or hinder HIV serostatus disclosure and risk reduction practices among HIV-positive MSMs and IDUs with HIV-negative partners or partners of unknown status.
- Identify feasible intervention strategies to promote the prevention of HIV transmission among HIV+ MSMs and HIV-positive IDUs.

Researchers have already learned several things about the participants in the study, including:

- MSMs and IDUs living with HIV continue to be sexually active after diagnosis of infection and have distinct prevention intervention needs.
- HIV-positive IDUs are engaging in similar sexual behaviors with HIV-positive and HIV-negative partners.
- HIV-positive IDUs are reporting riskier sexual behaviors with their main partners as compared to secondary partners.
- HIV-positive MSMs are reporting rates of unprotected sex similar to those reported by HIV-negative MSMs.

- HIV-positives MSMs are using some harm-reduction strategies to prevent transmission of HIV.

Gomez and her colleagues have identified several themes in their SUMS and SUDIS studies. Many MSMs reported lack of control over their own behavior, often linked to use of substances and occasionally, threats of violence. Characteristics of partners were another important factor in risk taking, including the attractiveness of the partner and his role in the sexual encounter. Assumptions about status – without verbal confirmation – were frequently observed.

Researchers learned that many of the IDUs in their study are in relationships with people they have known much of their lives, and who are knowingly engaging in risky behavior. Economics plays a critical role and many HIV-positive women reported frequent exchange of sex for drugs. Many of these women have little or no control over the kind of sex they have in these situations.

Gomez was also involved in studying an intervention for serodiscordant heterosexual couples (the California Partners Study). The intervention was four sessions, followed by two “booster” sessions. It was focused on couples, but each member of the couple came in for his or her own separate sessions. The intervention was developed with the input of HIV-infected individuals and their negative partners. Researchers found that many of the couples in the intervention were consistently engaging in unprotected vaginal intercourse.

The expressed need for “love and intimacy” plays an important role in sexual decision-making. According to Gomez, some “couples simply feel that they do not want to carry HIV into the bedroom.” For other couples, economics was a key issue. These couples had the perception that HIV infection actually connects people with important resources and they therefore did not see HIV infection as a completely negative consequence.

Gomez is currently also working on *SUMIT* (Seropositive Urban Men’s Intervention Trial), a new intervention for HIV-positive MSMs about to be launched. This will be a six-session intervention that will bring together 50 HIV-positive men. The goal is to create a social environment that does not feel like a traditional support group.

In addition, Gomez recently received a grant to do a study on HIV-positive IDUs. The study, called *INSPIRE* (Intervention for Seropositive Injectors – Research and Evaluation), will develop an intervention to reduce sexual risk and increase utilization of HIV care and treatment and adherence.

Serodiscordant Couples

Robert Remien – Columbia University

Robert Remien is working on an NIMH-funded study of a group intervention for gay male serodiscordant couples. Couples came together in groups for eight sessions. The design was based on earlier interviews researchers had done that identified high levels of distress and hopelessness as well as feelings of isolation among these couples.

Remien has identified several themes in his research relative to sexual risk. The “most significant” finding was the expressed “desire for intimacy, desire to be close...the desire to be ‘as close as I can with my partner.’” Remien has found the same concern when working with heterosexual partners. Researchers also have observed that when partners in the study practiced risky behavior, it was often at the request of the HIV-negative partner. Many of the men in the study reported being surprised by some of the comments made by their partners during the group sessions. Remien reported “When it comes to issues around risk behavior, they’re often

experiencing the same fears and concerns but they're not expressing them to each other because they feel a need to 'protect' each other emotionally. This avoidance of communication can contribute to taking behavioral risks."

Retention of participants has been a major challenge in the intervention and several of the couples initially enrolled in the study have broken up. Remien believes this is because couples who are having relationship difficulties are drawn to the intervention. However, Remien has noted the important potential of working with couples and the ability to engage in difficult issues around prevention, risk and taking care of each other by working with both members of the couple. Many of the HIV-positive individuals in the study were concerned about several issues in addition to preventing transmission of the virus, including self-protection, acquisition of sexually transmitted diseases (STD) and re-infection, as well as medical treatment issues, dealing with uncertainty and making future plans.

Women in Non-urban Communities

Gina Wingood – Emory University

Gina Wingood is studying an intervention called "Willow," (Women Involved in Life, Learning from Other Women), a group intervention designed for HIV-positive women primarily in non-urban communities. The program focuses on two issues: enhancing quality of life and reducing unsafe sex among participants. One goal of the intervention was to build the social networks of the women participants, because these networks do not exist for many women in rural communities.

The intervention was divided into four sessions:

The first session focused on gender pride. This session was designed to enhance women's self-worth, self-esteem and sense of pride. Session activities included examining important women in the participants' lives and discussions about things in the participants' lives of which they are proud.

The second session concentrated on emotion-focused coping skills. Women in the group noted that they have much stress in their lives and face great challenges in coping with stress. Relaxation techniques, exercise, journal writing and assertiveness were all discussed during this session.

The third session focused on risk reduction, including condom use, sexual negotiation skills and potential risks of super-infection.

The fourth session dealt with healthy relationships and addressed fear of abandonment, fear of status disclosure to partners and emotional and physical abuse. No data is available yet on the effectiveness of this intervention, but retention in the program has been impressive: the six-month follow up rate was 100%.

Clinicians as Prevention Providers

William Fisher – University of Western Ontario and

Jeffrey Fisher – University of Connecticut

William Fisher and Jeffrey Fisher are working on formative research on an intervention targeted to clinicians and the HIV-positive clients they serve. The program is based on the assumption that many HIV care clinicians are not sufficiently skilled to provide HIV prevention services to their clients. The goal is to develop a physician-directed HIV prevention intervention for people with HIV that can be delivered over time and that is easy to integrate into the context of continuing primary medical care.

Fisher and Fisher intend to integrate laptop computers into the intervention. These laptops would be used to collect individualized information from patients and generate a patient profile. A prescription pad will be used for physicians to “prescribe” prevention. Clinicians will be trained to be empathetic and non-judgmental, as well as to conduct motivational dialogue with patients on HIV prevention issues.

Reaching People in Prison Facilities

Olga Grinstead – University of California, San Francisco

Olga Grinstead and her colleagues at the Center for AIDS Prevention Studies (University of California, San Francisco), worked in collaboration with Centerforce, Health Programs Division to develop and test an 8-session pre-release intervention for HIV-positive inmates at a state prison. They found that men who attended the intervention session reported more use of community resources and less sexual and drug-related risk behavior in the months following their release compared to men who signed up for the program but were not able to attend.

Summary of Slides from Walt Senterfitt’s presentation on HIV+ Partners in Prevention at the Community Planning Leadership Summit in Houston (March, 2001)

Oasis Clinic

Two-stage PCRS for Women

First stage:

- 85 women, 68 infected heterosexually
- 61 knew all sex partners
- 53 knew how to contact them
- 46 male partners found and interviewed
- 33 male partners HIV-positive, 9 unaware
- 23 aware of HIV status

Second stage:

- 14 women contacted from 9 unaware men
- 6 found to be positive, all 6 unaware
- 31 women contacted from 23 aware men
- 22 found to be positive, 14 already aware
- 8 (14 total) previously unaware of HIV+
- Median CD4 count PCRS women = 411
- Median CD4 count other women = 156

Targeted Outreach/Focused Intervention:

Focused Intervention A:

- Sexually active male patients asked “Could you identify friends or acquaintances still engaging in unprotected sex?” 84% said “Yes.”
- “Would you be willing, after some training and practice, to contact them to come in for counseling and testing?” All said “Yes.”

Focused Intervention B:

- Sexually active male clients asked: “Could you identify friends or acquaintances whom you feel are HIV positive and have not been tested?” 100% said “Yes.”

- “After orientation and practice, would you be willing to approach them and invite them in for counseling and testing?” All agreed.

Results

- A: 17/30 tested were HIV+, 9 unaware
- B: 11/15 HIV+, 3 aware and not in care, 8 previously unaware
- Expanded program: 31 existing patients
- Recruited 79 for counseling and testing
- 77 accepted testing (66 first HIV test)
- 37 (48%) were HIV+: 24 male, 3 female, 10 transgender

Summary:

- One-week survey of all sexually active male clients: 67% admitted occasionally being “unsafe” as they understood the term
- 84% said they could identify friends who had unsafe sex or were likely to be positive
- 100% of these said they would help if there were a structured program to allow someone to contact them discreetly
- Background test-positive rate = 1.5%
- Depends on physician or nurse approaching patients once trust is established
- Modest incentives (2 movie tickets for each person bringing in a friend, and 2 for each person so referred)
- Immediate access to care and social services offered (62% chose to accept care at Oasis)

S.T.O.R.E.—APLA Alliance (Los Angeles)

- Satellite Testing Office for Research and Evaluation is (STORE) is walk-in or appointment ATS/CTS site in high-incidence area and near gay bars/businesses
- HIV+ test rate 5-7%
- Clients testing positive offered CD4 and viral load testing and rapid medical and social service appointments
- Clients also offered “Positive Buddy”
- AIDS Project Los Angeles (APLA) recruits and trains client volunteers to serve as positive buddies
- STORE client can call buddy, allow number to be given for buddy to contact, or meet at STORE
- Buddies talk at least once/week
- Buddies are trained in ‘active listening,’ sharing personal stories if/when asked, linking to APLA staff for services and detailed information
- Of first 25 newly-tested HIV+ clients, 20 accepted offer of buddy referral, 19 successfully connected
- 10 made immediate medical appointments, 10 chose not to
- Of 10 who deferred, 8 made medical appts within 6 months
- 15/19 clients accepting buddies had made regular connection to non-medical services or peer support within six months
- All clients with buddies who initiated medical treatment or monitoring reported still being in care at 12 months follow up
- Buddies attended 3-day training before beginning service, and 4-hour in-service per month

- Buddies receive a one call once a week from supervising staff member, who is on call in case of emergency or need
- Buddies receive meals, childcare, transportation plus \$10 stipend for each training session or in-person buddy meeting

The Bridge Project—CA PHIPP

- PHIPP = Prevention for HIV-Infected Persons Project
- State of California is one PHIPP area
- First part of CA PHIPP is the HIV Transmission Prevention Project, with enhanced prevention case management in 11 EIP sites
- Second part is Bridge Project in 10 counties
- Community-based peer outreach worker attached to EIP and at least one CBO and one test site
- Statewide training in outreach methods, treatment education/advocacy, and peer prevention counseling/support
- Referral/connection will be offered to each person receiving positive test result at affiliated site(s) and CBO(s)
- EIP will refer clients with whom contact has been lost, or who have trouble with adherence or keeping appointments
- Bridge peer workers will provide peer-to-peer conversation and emotional support, treatment and transmission information, company/assistance for initial referrals, clinic visits, disclosure meetings, etc.

PCM literature notes (such as they are)

Richardson DA, Ward MA, Wiersema JJ, et al. (1999) HIV prevention case management for incarcerated persons: Maryland's unique approach. *National HIV Prevention Conference 1999* Aug 29-Sep 1 (abstract no. 404).

Setting: Four pre-release units within the Division of Correction and local detention centers in 14 Maryland counties. Target male and female inmates who are within 6 months of release from incarceration. Program evaluated via a self-efficacy instrument developed to measure attitudes and intent to change behaviors regarding condom use, harm reduction practices involving drug paraphernalia and risk reduction practice while under the influence of drugs and/or alcohol.

Outcomes: 3 scales on the pre-post test survey to measure change. . Participants demonstrated statistically significant improvements on all 3 scales, but changes small in magnitude. Inmates who completed PCM spent an average of 10 hours in intervention. The greater the amount of time spent in the individual sessions, the greater improvement in scores.

Comment: No indication of what follow-up period was or how many inmates involved. No control group.

Other abstracts from *National HIV Prevention Conference 1999* Aug 29-Sep 1:

- PCM program in Chicago for high-risk negatives. No outcome data.
- PCM program in Western Queens, NY for Latino MSM. No outcome data.
- PCM program in Salt Lake City for incarcerated female injection drug users and commercial sex workers. No outcome data.

Excerpt from CDC's HIV Prevention Case Management Manual, September 1997
(at www.cdc.gov/hiv/pubs/hivpsml.htm)

2.3 PREVENTION CASE MANAGEMENT

In the next two sections, the limited literature on PCM will be examined. Note that all of the studies on PCM were completed before CDC published its initial guidelines in 1995.

2.3.1 Published Literature

PCM is a hybrid intervention, attempting to provide time-limited case management and HIV prevention services. PCM is based on the idea that people are unable to prioritize the threat posed by HIV when they face problems they perceive as more important and immediate (Falck et al., 1994). By addressing these acute needs through case management, high-risk persons who would not typically seek other risk-reduction programs might be reached for HIV prevention efforts. For example, a recent study found that poor mental health and drug dependence may undermine the ability and motivation of female sex traders in Harlem to adopt safer sex behavior (El-Bassel et al., 1997). A PCM intervention for this population would attempt to address the women's psychosocial and mental health needs and provide risk-reduction counseling so that they would be more likely to adopt safer sex practices. As discussed, however, one of the salient features of case management, including PCM, is that the core services provided by the case manager are not sought by every client. In other words, PCM clients may not come to an agency or a health department to seek prevention services, even though HIV prevention is the primary purpose of the program.

Only a few reports on PCM have been published or presented. Three reports focus exclusively on HIV-seropositive persons (CDC, 1993; Schwartz, Dilley, & Sorenson, 1994; Thurnherr, Moore, Bonk, & Strum, 1994), and one focuses mostly on HIV-seronegative individuals (Falck et al., 1994). Two of the studies provide very limited outcome evaluation data.

The CDC (1993) reported outcome data on PCM programs for HIV-seropositive persons in three community health centers. The goal of PCM at these three sites was to assist HIV-seropositive clients in obtaining services that would prevent or reduce behaviors that result in further spread of the virus, delay the onset of symptomatic HIV disease, and improve the client's health. Clients attended a follow-up visit after testing positive, during which the case manager collected data on risk behavior (five items), provided risk-reduction counseling, and developed a care plan for medical and psychosocial services (Time 1). Clients' next scheduled meeting with the case manager was 4 to 6 months after the first visit, and the risk questionnaire was readministered (Time 2). No other PCM activities took place between Time 1 and Time 2. Although 755 clients received PCM services at the three sites, because of changes in methodology, only 61 clients completed the same questionnaire at Time 1 and Time 2. At Time 2, significantly more of these clients had not had sex in the past 30 days and reported no current sex partner, than at the beginning of PCM. However, no differences were found in the number of new sex partners or the use of condoms with a regular sex partner.

Even though these findings are somewhat encouraging, they do not provide a very good test of the efficacy of PCM in decreasing high-risk behaviors. Problems include the small sample size, the lack of control for disease progression (which could have caused a decrease in sexual activity), and the failure to collect behavioral data in the time between HIV testing and the first case management appointment (a 2.4-month lag time on average, during which time changes could have occurred). In addition, interpretation of the findings on condom use is difficult because the serostatus of sex partners is not known. Furthermore, the intensity of the PCM services delivered at these program sites is unclear. The PCM intervention in this case seems to have consisted of two meetings with a case manager, although few details were provided.

In a randomized controlled trial of a PCM program in Ohio for injection drug users (most of whom were HIV-seronegative), no differences were found between three groups of participants (case management, health education, and control) with regard to drug use, risky sexual behaviors, or use of human services at 6-month follow-up (Falck et al., 1994). Participants in all three groups reported significantly less drug

risk, but no change in high-risk sexual practices at follow-up. Although no evidence of behavioral change was found in this study, the difficulty in retaining participants suggests that it may not have been an adequate test of the PCM model. To try to increase the number of clients completing the intervention, the researchers changed their initial PCM plan (a minimum of six sessions with the prevention case manager) to one initial office visit and two sessions in the field. Even with this adjustment, retention was difficult. Of the 105 clients randomly assigned to the case management intervention, 66% agreed to further participation after the first office visit; 49% participated in at least one field visit; and only 37% participated in two or more field sessions. Thus, data were available only for the 38 participants who received at least two case management sessions.

These authors focused most of their commentary on the difficulty of getting clients to "engage" in the program (the first step in their six-step case management model) and to remain in the program. They were discouraged by the fact that, "the clients expressed a nearly uniform lack of interest in what the project offered" (Falck et al., 1994, p. 165). Given the intense effort that was needed to engage clients for the first session, Falck and his colleagues were disappointed in the retention rate. They concluded that the effects of drug use worked directly against the engagement and retention of clients in the case management process. Another possibility not mentioned by the authors is that because most clients were HIV-seronegative, they were less interested in primary prevention, and hence, in the HIV PCM program.

Schwartz and her colleagues (1994) reported on a case management model with HIV-seropositive substance-abusing persons that focused on decreasing drug usage, linking clients to services, and decreasing the risk of HIV transmission. Although no outcome data are available yet from this project, Schwartz and her colleagues did describe some difficulties with addressing prevention issues in the context of case management. She noted that AIDS issues were not primary for many clients and could not be addressed effectively until basic needs were met. They found, however, that meeting basic needs for this substance-abusing population was very difficult because of the number of obstacles faced by clients, including

- lack of money
- lack of child care
- lack of transportation
- lack of a telephone
- lack of necessary documentation (for example, identification or social security card, citizen-ship papers)
- active substance abuse
- poor physical health
- mental illness
- eviction or criminal history
- long waiting lists or lines for services
- few services for people who were not HIV-seropositive and who were not disabled

To the extent that persons in PCM cannot become engaged in the process (and thereby get their basic needs met), implementing the prevention component of PCM becomes more difficult. Moreover, as seen from this list of obstacles, many of these barriers are significant. Clearly, long-standing individual or social issues may be difficult to overcome with any social program, let alone an HIV prevention intervention.

The final PCM-like program was a 60-day peer-based program in which clients who had recently tested seropositive were matched with seropositive agency *veterans* (Thurnherr et al., 1994). On the basis of focus groups with new and veteran clients, the agency determined that the biggest obstacles to services for new clients were the complexity of the service system and the clients' feelings of isolation. The clients with recent diagnoses also exhibited substantial confusion about safe sex practices. Thurnherr and his colleagues designed a 60-day, 6-session intervention in which the agency veterans led newcomers through training on safe sex alternatives, correct condom usage, personal responsibility and HIV, choices of early medical intervention, HIV basics, and STD education. The authors did not state whether or not traditional case management activities such as assessment, linking to services, and monitoring were provided. Although the authors called the intervention a peer PCM program, it seems to be more similar to risk-reduction programs and buddy programs for HIV-seropositive persons than to the usual PCM

program. No outcome data were presented, and a phone call to the agency revealed that the program has been discontinued.

2.3.2 Conclusions

From the few publications on PCM, several points stand out. First, client engagement and retention are difficult with multiproblem, high-risk clients such as those who abuse substances. This difficulty is important because the goal of PCM is to reach such persons. Second, providing social services to high-need, multiproblem clients, let alone HIV prevention services, is difficult. Third, many PCM clients do not perceive a need for HIV prevention services, and this might be especially true for those who are HIV-seronegative. Finally, PCM programs have not been evaluated; thus, conclusions about the effectiveness of PCM are not warranted.

Transgender Sub-Population

Notes

Bockting WO, Rosser BRS, Coleman E (2000) Transgender HIV Prevention: A Model Education Workshop. *Journal of the Gay and Lesbian Medical Association* 4: 175-85.

Note: This group has published several articles based on the focus groups they conducted and intervention they developed and implemented. These notes jumble them all together.

A university-based human sexuality program collaborated with transgender and HIV/AIDS community organizations to develop one of the first HIV prevention programs targeting the transgender community. Based on focus group data outlining specific intervention needs, we designed, implemented, and evaluated a model prevention education workshop.

Transgender-specific recommendations for HIV prevention from focus groups:

- Target materials and interventions to transgender community.
- Recognize the diversity and uniqueness of community. Don't lump all transgendered people together.
- Affirm transgender identity.
- Combat isolation.
- Need personal and community empowerment.
- Peer education.
- Meeting people with HIV/AIDS
- Treat compulsive sexual behavior.
- Educate health professionals.
- Transgender HIV/AIDS support group
- Use confidential, secure location.
- Provide opportunity to meet other transgendered people.
- Make it fun.
- Develop targeted advertisements eroticizing safer sex.
- Need street outreach.
- Client incentives.

The 4-hour workshop included large- and small-group meetings with presentations, discussions, role playing, and exercises based on the Health Belief Model, the Eroticizing Safer Sex approach to HIV prevention, and principles of personal and community empowerment. Transgender-sensitive audiovisual materials were developed; sexually explicit materials were incorporated. Transgender peer educators facilitated the workshop. Evaluation using a pre-, post- and 2-month follow-up test design showed an increase in knowledge and an initial increase in positive attitudes that diminished over time. Due to the small sample size (n=59) and limited frequency of risk behavior, a significant decrease in unsafe sexual or needle practices could not be demonstrated. However, findings suggested an increase in safer sexual behaviors such as (mutual) masturbation. Peer support improved significantly.

Kammerer N, Mason T, Connors M (1999) Transgender Health and Social Service Needs in the Context of HIV Risk. *The International Journal of Transgenderism*, vol. 3, pp?

Recommendations for HIV prevention

- Training on transgender issues for HIV-related service providers.
- Transgender-targeted HIV prevention outreach.
- Risk network-targeted HIV prevention.
- Transgender-appropriate HIV prevention literature.
- Social acceptance and support.

Clements K, Wilkinson W, Kitano K, Marx R (1999) HIV Prevention and Health Service Needs of the Transgender Community in San Francisco. *The International Journal of Transgenderism*, vol. 3, pp?

Based on focus groups, has following recommendations:

- Outreach should be conducted by workers who are members of the transgender community.
- Interventions need to be transgender specific. Gender identification not currently addressed in HIV risk reduction education and counseling sessions.
- Support groups should include: education about condom use and safe hormone/drug injections; improving self-esteem; developing safer sex negotiation skills; and helping clients build job skills to facilitate transition out of commercial sex work.
- HIV education, media, and referral materials not developed for non-transgendered populations and information is not factually or culturally appropriate for the transgender community.

**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 3

**REGIONAL EPI
PROFILES
EPI PRESENTATION
OVERHEADS**

AIDSNET REGION 1

HIV/AIDS EPIDEMIOLOGIC PROFILE

Update 2001

**Adams, Asotin, Columbia, Ferry, Garfield,
Lincoln, Okanogan, Pend Oreille, Spokane,
Stevens, Walla Walla, and Whitman Counties**



**Assessment Unit
Infectious Disease and Reproductive Health**

HIV/AIDS Epidemiologic Profile AIDSNET Region 1 – Update 2001

Purpose

The purpose of this report is to give people involved in HIV prevention community planning in Region 1 updated information related to HIV/AIDS and other related surrogate markers. Although it contains much of the data necessary for the decision-making process, it is not all-inclusive, and does not contain information from all possible data sources, definitions of terms, and information about data sources. It is recommended that readers consult the **1998 AIDSNET Region 1 HIV/AIDS Epidemiologic Profile** for further information.

What's new?

Nationally, the rates of decline in AIDS incidence and deaths resulting from the impact of highly active antiretroviral therapy slowed during the latter part of 1998 and 1999. This "stalling" of the trends appears to be taking place at the local level as well. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. At the same time, AIDS prevalence has been increasing, although the rate of increase has slowed. Prolonged health and survival of those who have been diagnosed with AIDS has brought about new challenges in prevention.

In terms of data collection, the biggest change was the initiation of HIV reporting in September, 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were demonstrated, in part, by the AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. The strengths and limitations of these data are described further in the HIV section. Additionally, initiation of HIV surveillance may have been a contributing factor to the increase in AIDS case reporting due to enhanced lab-based reporting and increased attention to surveillance in general.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although seroprevalence rates and case numbers had been decreasing in men who have sex with men (MSM), there is some evidence that these populations are experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color. Optimism about treatment successes may have brought about complacency, but HAART is no substitute for primary prevention. As new recommendations come out to

delay therapy in those who are HIV+, the strategy of “treatment as prevention” may not apply, and the focus needs to return to behavior change.

The year 2000 also brought about renewed focus on prevention in those who are HIV+. The Center for Disease Control’s HIV Prevention Strategic Plan prioritizes people living with HIV as a population to reach in order to reduce the number of new infections. The goal is to increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition. The Institute of Medicine recognized in its report, “No Time to Lose,” that those who are HIV-infected are in “a unique position to stop the spread of HIV.”

Demographic characteristics of Region 1

Table 1 presents some of the demographic characteristics of Region 1, including both the 1990 census figures and the 2000 estimates (2000 census data are not yet available). Comparison of the distribution of the general population and the distribution of those with HIV/AIDS allows for identification of populations that are overrepresented in the epidemic.

Table 1. Characteristics of the AIDSNET Region 1 Population, 1990 and 2000

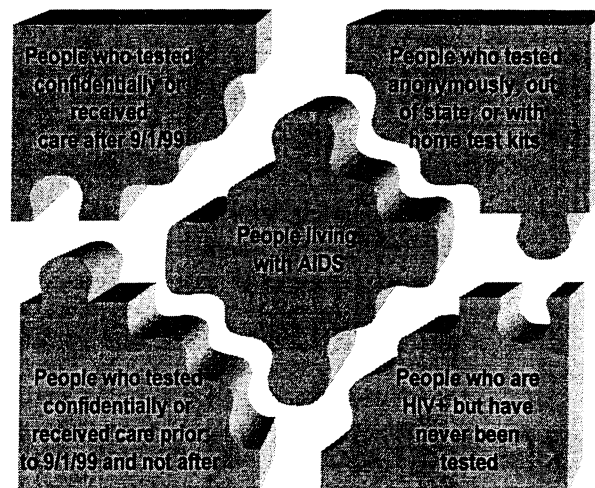
	1990 Census	2000 Census (est.)
Total population, Region 1	574,430	658,381
% of Washington State population	12%	11%
County population (% of Region 1)		
Adams	13,603 (2%)	15,768 (2%)
Asotin	17,605 (3%)	20,308 (3%)
Columbia	4,024 (1%)	4,127 (1%)
Ferry	6,295 (1%)	7,325 (1%)
Garfield	2,248 (<1%)	2,343 (<1%)
Lincoln	8,864 (2%)	9,641 (1%)
Okanogan	33,350 (6%)	37,979 (6%)
Pend Oreille	8,915 (2%)	10,904 (2%)
Spokane	361,364 (63%)	415,233 (63%)
Stevens	30,948 (5%)	37,861 (6%)
Walla Walla	48,439 (8%)	54,858 (8%)
Whitman	38,775 (7%)	42,034 (6%)
Gender		
Female	291,543 (51%)	331,094 (50%)
Male	282,887 (49%)	327,287 (50%)
Race/Ethnicity		
White	524,466 (91%)	582,388 (88%)
Black	6,378 (1%)	7,827 (1%)
Hispanic	21,150 (4%)	36,581 (6%)
Asian	9,675 (2%)	16,104 (2%)
American Indian/Alaska Native	12,761 (2%)	15,481 (2%)
Age		
<=14	128,472 (22%)	142,873 (22%)
15-19	43,940 (8%)	54,396 (8%)
20-29	88,799 (15%)	90,698 (14%)
30-39	92,493 (16%)	89,909 (14%)
40-49	72,001 (13%)	99,619 (15%)
50-59	48,258 (8%)	73,506 (11%)
60+	100,467 (17%)	107,380 (16%)

Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.

HIV data

Preliminary HIV data from Region 1 include HIV cases reported to DOH through 12/31/2000. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 1. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Region 1
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.

- Are not representative of all HIV-infected individuals. As can be seen in **Figure 1**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Preliminary data for Region 1 are presented in **Table 2**. HIV cases have been reported from all counties in Region 1 except Ferry, Garfield, and Lincoln Counties. The year of diagnosis (earliest available positive test result) ranges from 1984 to 2000. When compared to recently diagnosed AIDS cases, the HIV cases include a higher proportion of women and, consequently, a higher proportion of cases due to heterosexual transmission. HIV cases also include a higher proportion of cases with no identified risk, primarily because these cases are earlier in the course of infection and may not know their risk factors or may not have shared the information with a provider. Additionally, many HIV cases are identified through laboratory reporting, so risk is more difficult to ascertain. In terms of age, the age of HIV diagnosis is younger than the age of AIDS diagnosis, as expected, so a higher proportion of cases is under the age of 30.

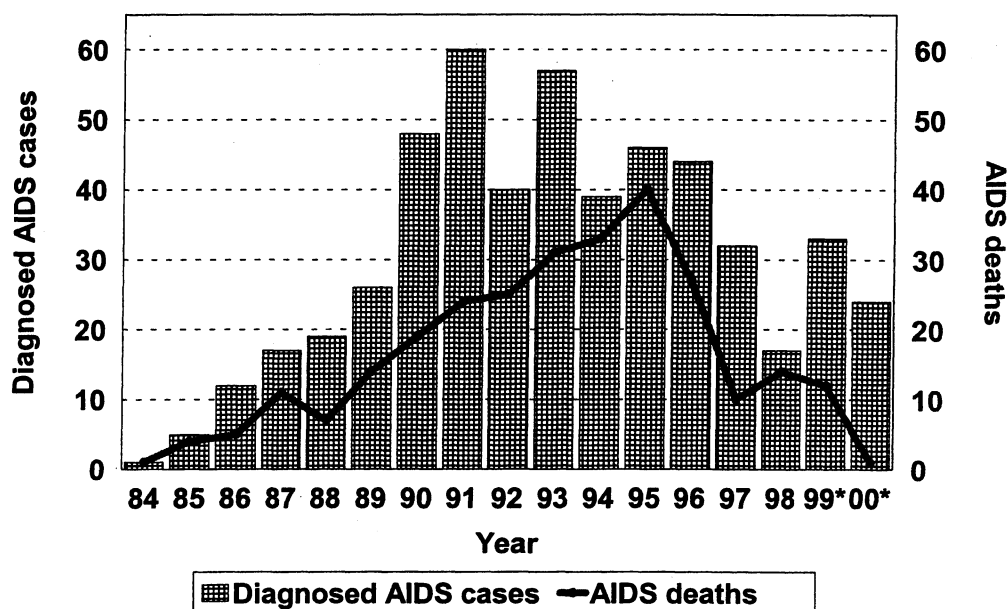
Table 2. HIV infection reported for Region 1 (As of 12/31/2000)
N = 105

County		
	Adams	1 (1%)
	Asotin	1 (1%)
	Columbia	1 (1%)
	Ferry, Garfield, Lincoln	0 (0%)
	Okanogan	4 (4%)
	Pend Oreille	1 (1%)
	Spokane	88 (84%)
	Stevens	3 (3%)
	Walla Walla	4 (4%)
	Whitman	2 (2%)
Year of diagnosis		
	1984-1989	23 (22%)
	1990-1995	35 (33%)
	96	8 (8%)
	97	9 (9%)
	98	10 (10%)
	99	10 (10%)
	00	10 (10%)
Gender		
	Male	86 (82%)
	Female	19 (18%)
Race/Ethnicity		
	White	82 (78%)
	Black	11 (10%)
	Hispanic	5 (5%)
	Asian/Pacific Islander	0 (0%)
	American Indian/Alaska Native	3 (3%)
	Unknown	4 (4%)
Mode of exposure		
	MSM	44 (42%)
	IDU	21 (20%)
	MSM/IDU	11 (10%)
	Heterosexual	12 (11%)
	Receipt of blood products	0 (0%)
	Other/Unknown	17 (16%)
Age		
	<13	3 (3%)
	13-19	2 (2%)
	20-29	45 (43%)
	30-39	30 (29%)
	40-49	19 (18%)
	50-59	6 (6%)
	60+	0 (0%)
Disease status		
	Asymptomatic HIV	67 (64%)
	Symptomatic HIV	38 (36%)

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 2** demonstrates the significant declines in AIDS incidence and deaths in Region 1 experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies. It also shows the “stalling” of these trends after 1998.

Figure 2. AIDS cases by year of diagnosis and AIDS deaths, AIDSNET Region 1, 1984 – 2000 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The decline in HIV-related mortality has led to an increase in AIDS prevalence. As can be seen in **Figure 3**, the number of people living with AIDS in Region 1 has been increasing, adding to the challenge of providing prevention and care services.

Figure 3. Number of people living with AIDS, AIDSNET Region 1 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete.)

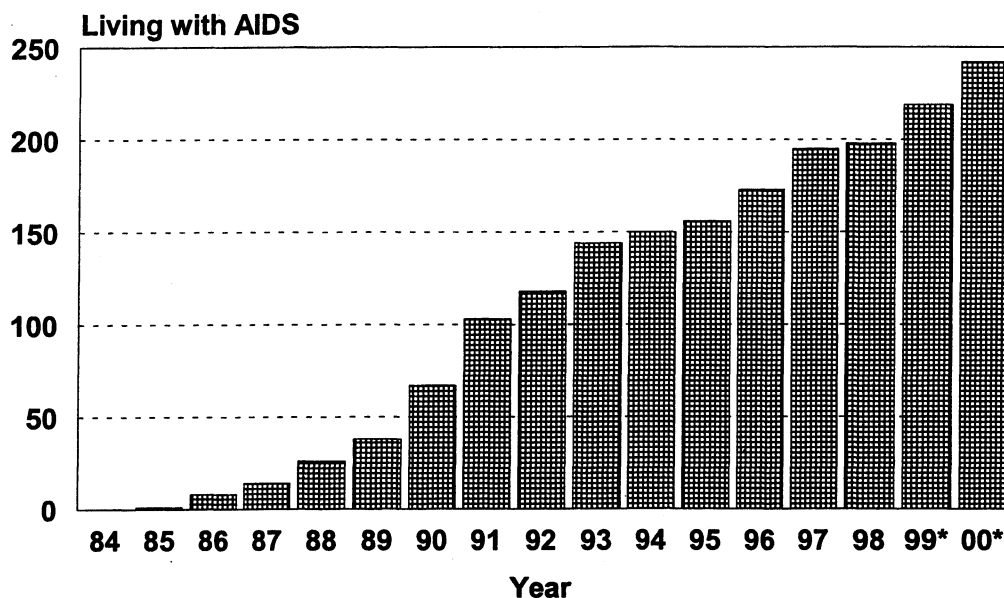


Table 3 describes the changes in the distribution of AIDS cases over time in Region 1. AIDS cases have included an increasing proportion of women, cases due to injection drug use and heterosexual transmission, and people of color, particularly Blacks and Hispanics. Additionally, the proportion of those diagnosed with AIDS who are over 40 years of age has been getting larger. This increase may be due, in part, to the ability of the new therapies to keep people from reaching an AIDS diagnosis until a later point in time.

Table 3. AIDS case trends over three time periods, AIDSNET Region 1

	Year of diagnosis		
	1985-1989 n = 79	1990-1994 n = 244	1995-1999 n = 172
Gender			
Male	95%	94%	90%
Female	5%	6%	10%
Mode of exposure			
MSM	65%	64%	49%
IDU	10%	13%	20%
MSM/IDU	14%	9%	10%
Heterosexual	0%	7%	8%
Receipt of blood products	9%	3%	3%
Other/Unknown	3%	4%	11%
Race/Ethnicity			
White	89%	88%	83%
Black	4%	4%	5%
Hispanic	6%	4%	8%
Asian/Pacific Islander	0%	1%	0%
American Indian/Alaska Native	1%	3%	2%
Unknown	0%	0%	2%
Age			
<13	0%	0%	1%
13-19	3%	1%	1%
20-29	25%	21%	12%
30-39	48%	44%	48%
40-49	14%	20%	24%
50-59	6%	9%	12%
60+	4%	4%	2%

HIV/AIDS in behaviorally-defined populations

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of AIDS cases. In Region 1, 54% of those living with AIDS were men exposed through sex with other men. Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Region 1.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories by gender, race/ethnicity, and region of residence for the 241 adults and adolescents living with AIDS who were diagnosed in Region 1.

In looking at these tables, it is important to note that although MSM account for the majority of Region 1 AIDS cases (both inside and outside of Spokane County), cases among other HIV exposure categories have occurred and are of particular significance among women and persons of color (Tables 4-6).

Table 4. Adults and adolescents living with AIDS, by HIV exposure category and sex, AIDSNET Region 1. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Region 1 Total
Men who have sex with men (MSM)	129 (58%)		129 (54%)
Female and heterosexual male injection drug users	38 (17%)	6 (35%)	44 (18%)
MSM who use injection drugs	24 (11%)		24 (10%)
Heterosexual contacts*	6 (3%)	9 (53%)	15 (6%)
Receipt of blood products	5 (2%)	0 (0%)	5 (2%)
Other/unknown	22 (10%)	1 (12%)	24 (10%)
TOTAL	224	17	241

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 5. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, AIDSNET Region 1. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).**

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	110 (56%)	2 (22%)	6 (35%)	1 (50%)	4 (44%)
Female and heterosexual male injection drug users	32 (16%)	4 (44%)	4 (24%)	0 (0%)	4 (44%)
MSM who use injection drugs	23 (12%)	0 (0%)	0 (0%)	0 (0%)	1 (11%)
Heterosexual contacts*	11 (6%)	1 (11%)	2 (12%)	0 (0%)	0 (0%)
Receipt of blood products	4 (2%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)
Other/unknown	17 (9%)	2 (22%)	4 (24%)	1 (50%)	0 (0%)
TOTAL	197	9	17	2	9

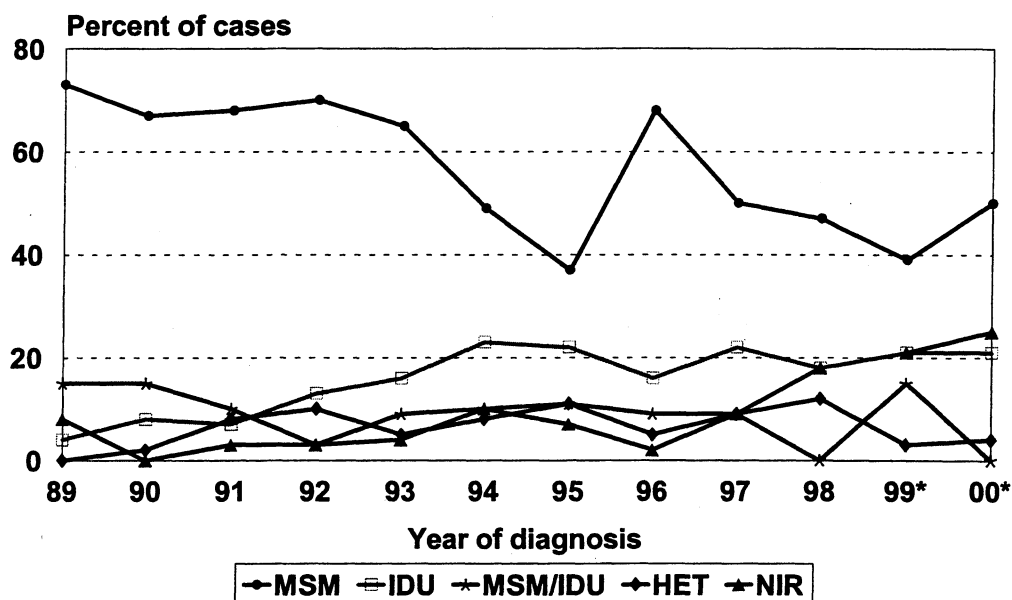
*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes seven people of unknown race/ethnicity.

Table 6. Adults and adolescents living with AIDS, by exposure category and residence at AIDS diagnosis, AIDSNET Region 1. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 still not considered to be complete).

HIV Exposure Category	Non-Spokane Counties	Spokane County	Total
Men who have sex with men	23 (33%)	106 (62%)	129 (54%)
Female and heterosexual male injection drug users	18 (26%)	26 (15%)	44 (18%)
MSM who use injection drugs	8 (11%)	16 (9%)	24 (10%)
Heterosexual contacts*	9 (13%)	6 (4%)	15 (6%)
Receipt of blood products	1 (1%)	4 (2%)	5 (2%)
Other/unknown	11 (16%)	13 (8%)	24 (10%)
TOTAL	70	171	241

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Figure 4. Proportion of AIDS cases accounted for by selected HIV exposure groups, AIDSNET Region 1, 1989-2000. (Note: Cases reported as of December 31, 1999; reporting for 1999 and 2000 is still not considered to be complete*.)



The proportion of AIDS cases attributable to MSM has been decreasing in Region 1 as it has in other areas of the state. **Figure 4** shows that the proportion of AIDS cases in this population has been decreasing, although not steadily, since 1991 (as a result of increases in cases in other transmission risk categories). The proportion of cases due to injection drug use has been increasing, and there has been a small but steady increase in the proportion of cases due to heterosexual transmission. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

HIV/AIDS in demographically-defined populations

A. Adolescents and young adults

AIDS cases and trends

AIDS cases in persons 13-29 years of age reflect HIV transmission which occurred during adolescence or early adulthood. Of the 520 AIDS cases diagnosed in Region 1 between 1982 and 2000, 99 (19%) have been among persons 13-29 years of age. Only about 1% of all cases have been diagnosed among persons 13-19 years of age; 18% have been

diagnosed among persons 20-29 years of age. Although the number of AIDS cases among persons 13-19 years of age has been relatively stable, cases among persons 20-29 years of age increased through 1991, decreased in the mid-1990s, and then appear to have leveled out (**Figure 5**). Since the majority of AIDS cases in this age category are attributable to MSM, this trend may in part reflect the statewide trends in white MSM.

All modes of HIV exposure have been reported among adolescents and young adults in Region 1 (**Table 7**). Twenty-six cases in 13-24 year olds have been diagnosed in males (93%), and two cases (7%) have been diagnosed in females. The majority of cases (39%) have been reported among young men who have had sex with men, with an additional four cases in young MSM who inject drugs.

Figure 5. AIDS cases among adolescents and young adults by year of diagnosis, AIDSNET Region 1, 1984-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*).

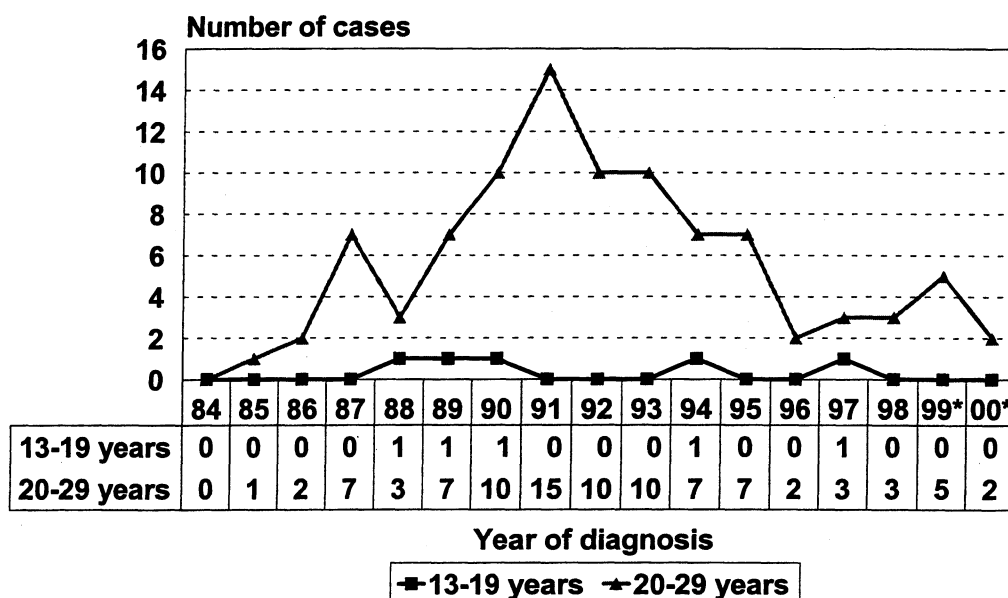


Table 7. Mode of HIV exposure among adolescents and young adults (13-24 years) by gender, AIDSNET Region 1, 1982-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

Exposure category	Number (%)
Men who have sex with men (MSM)	11 (39%)
Female and heterosexual male injection drug user	3 (11%)
MSM who used injection drugs	4 (14%)
Heterosexual contact*	4 (14%)
Receipt of blood products	5 (18%)
Not reported/unknown	1 (4%)
TOTAL	28

*Heterosexual contact with a person with HIV or known to be at risk for HIV.

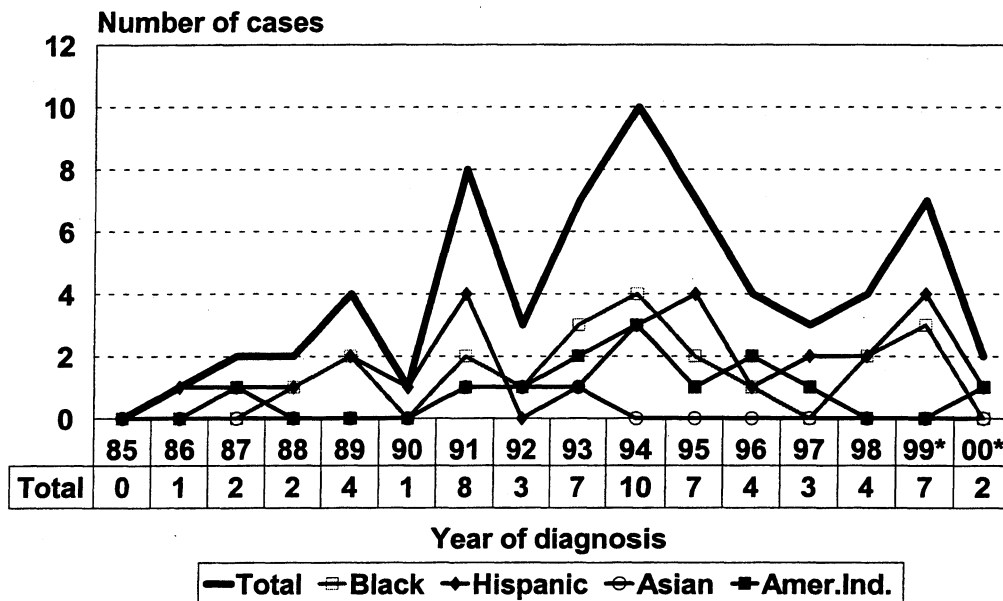
B. People of color

Although transmission of HIV results from certain high risk behaviors and is not the result of one's race or ethnicity, racial and ethnic minorities have been disproportionately affected by the HIV epidemic and, therefore, will be considered separately.

AIDS cases and trends

A total of 73 AIDS cases have been diagnosed between 1982 and 2000 among people of color who were residents of Region 1 at the time of diagnosis. These cases account for 14% of the AIDS cases from this region. The number of cases among people of color increased through 1994, then declined, and appears to perhaps be stabilizing (**Figure 6**). Since the numbers of cases are small, trends must be interpreted with caution. Of the 73 cases diagnosed in Region 1 among people of color, 37% have been diagnosed since 1995.

Figure 6. AIDS cases among people of color, AIDSNET Region 1, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*.)



C. Women

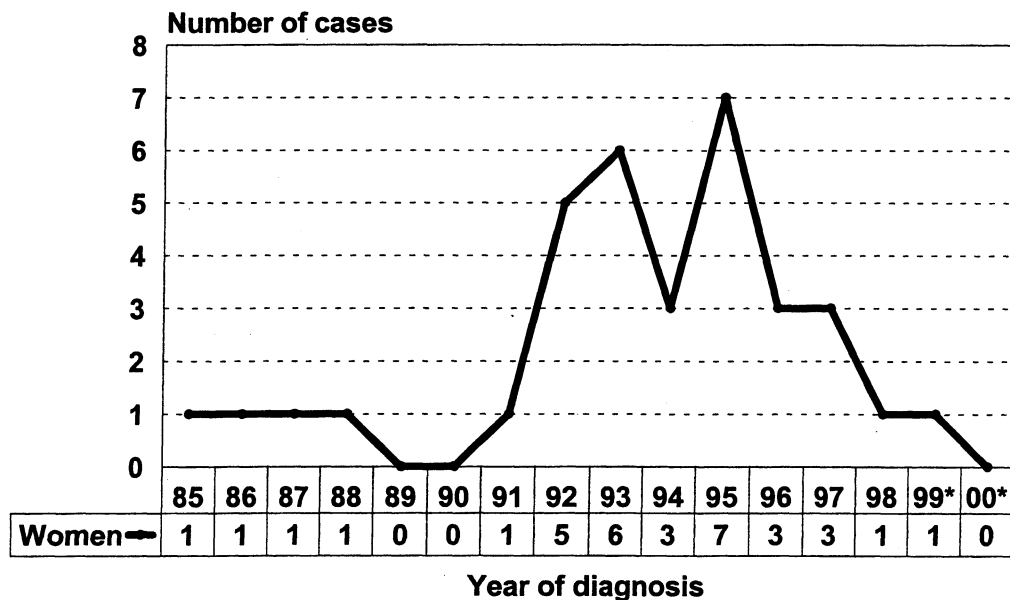
Women, as a general group, are not at increased risk for HIV. However, specific prevention programs can be targeted toward women (e.g., AZT during pregnancy); furthermore, the proportion of cases among women seems to be increasing as a result of increasing cases among injection drug users and their heterosexual partners. As a result, data on women are presented as a separate section.

AIDS cases and trends

From 1982-2000, 34 cases of AIDS were reported among women (≥ 13 years of age) who were residents of Region 1 at the time of diagnosis. The cases among women accounted for 7% of all Region 1 AIDS cases.

The number of AIDS cases among women in Region 1 increased through the mid-1990s and has declined in recent years (trends must be interpreted with caution due to small numbers) (**Figure 7**). Women have been making up a slowly increasing proportion of AIDS cases in Region 1 (**Table 3**).

Figure 7. AIDS cases among women by year of diagnosis, AIDSNET Region 1, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).



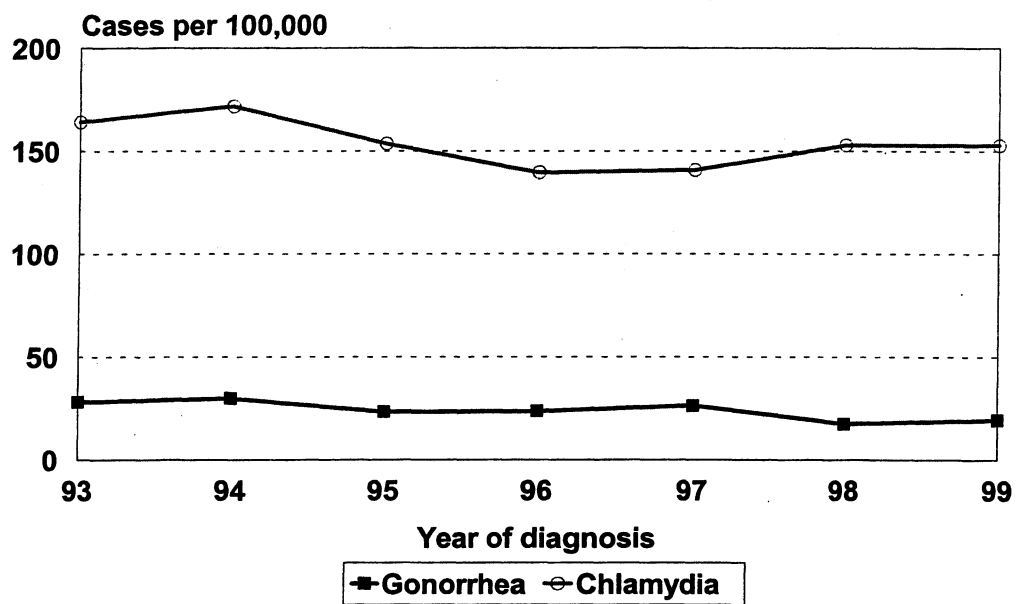
Of the 34 cases among women, 25 (74%) were white, four (12%) were Black, two (6%) were Hispanic, one (3%) was Asian/Pacific Islander and two (6%) were American Indian/Alaska Native.

The majority of cumulatively diagnosed women with AIDS in Region 1 (16 cases or 47%) acquired HIV from heterosexual contact with a person with HIV or known to be at risk for HIV (**Table 4**); 10 cases occurred among female injection drug users. Of the 16 cases resulting from heterosexual contact, 11 (69%) were due to heterosexual contact with an injection drug user, 3 (19%) were due to heterosexual contact with a bisexual male, and two (13%) were due to heterosexual contact with someone with HIV/AIDS (exposure risk unknown). The number of cases among women was too small to identify any differences in HIV exposure by race/ethnicity.

Surrogate indicators

In addition to HIV and AIDS-related data, it is important to consider other sources of data that may indicate risk behavior. **Figure 8 and Tables 2-4 in the Appendix** describe some of these surrogate indicators, none of which has dramatically changed in the last few years. STD case rates have been relatively stable over time, with higher rates in people of color and people who are younger. Teen pregnancy rates have also been stable. Hepatitis B cases have been declining over time and are a less useful indicator of risk behavior due, in part, to the availability of a vaccine. Chronic hepatitis C became reportable in December 2000, and data related to this indicator will provide information about certain at-risk populations in the future.

Figure 8. Chlamydia and gonorrhea case rates for Region 1, 1993 – 1999.



APPENDIX

Table 1. AIDS cases by county of residence at diagnosis, AIDSNET Region 1, 1984-2000 (Cases reported as of December 31, 2000.)*

COUNTY	YEAR															TOTAL	LIVING**
	<=87	88	89	90	91	92	93	94	95	96	97	98	99	00			
Adams	0	0	1	0	0	0	0	1	0	0	0	0	1	0	3	2	
Asotin	0	0	0	2	1	1	2	0	1	3	3	0	0	0	13	7	
Columbia	0	0	1	0	1	0	0	1	0	0	0	0	0	0	3	1	
Ferry	2	0	0	0	0	2	0	0	0	0	0	1	0	0	5	0	
Garfield	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Lincoln	0	0	0	0	1	0	0	1	0	0	1	0	0	0	3	1	
Okanogan	1	0	0	2	3	1	1	1	2	1	3	2	2	0	19	13	
Pend Oreille	0	0	0	0	2	1	2	0	2	1	0	0	0	0	8	4	
Spokane	30	17	19	39	46	32	40	29	29	31	21	11	26	16	386	171	
Stevens	0	0	0	2	1	0	5	0	2	2	1	1	2	1	17	11	
Walla Walla	2	2	5	2	3	3	7	6	7	6	3	2	1	4	53	26	
Whitman	0	0	0	1	2	0	0	0	3	0	0	0	1	3	10	6	
TOTAL	35	19	26	48	60	40	57	39	46	44	32	17	33	24	520	242	

*Due to delays in reporting, case counts for 1999 and 2000 are still not considered complete.

**Based on known deaths as of September 30, 2000.

Table 2. Cases of gonorrhea by county of residence at diagnosis, AIDSNET Region 1, 1982-1999.

COUNTY	YEAR																	
	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
Adams	11	21	3	9	7	4	3	3	2	2	1	4	3	4	4	2	1	1
Asotin	53	22	23	22	21	13	2	2	0	3	2	0	2	2	1	1	0	0
Columbia	2	0	6	0	6	5	0	1	0	0	0	0	0	0	1	0	1	0
Ferry	2	17	6	3	3	0	4	1	0	0	0	0	2	0	0	0	0	0
Garfield	0	0	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	7	4	0	1	3	2	0	0	1	0	0	0	1	0	0	0	0
Okanogan	61	101	74	55	72	59	60	32	17	11	7	6	4	4	6	5	10	5
Pend Oreille	1	7	9	6	3	2	2	1	0	2	3	0	3	1	0	0	2	0
Spokane	911	721	608	569	622	507	233	200	244	131	188	150	140	119	127	145	89	114
Stevens	14	21	20	9	29	17	25	6	3	1	4	4	6	3	2	7	0	4
Walla Walla	50	66	70	70	87	43	25	36	25	11	7	4	14	5	1	7	5	0
Whitman	22	19	27	25	28	14	8	10	15	11	4	3	10	7	10	4	6	3
TOTAL	1127	1002	850	768	881	669	364	292	306	173	216	171	184	146	152	171	114	127

Table 3. Cases of hepatitis B by county of residence at time of diagnosis, AIDSNET Region 1, 1988-1999.

COUNTY	YEAR											
	88	89	90	91	92	93	94	95	96	97	98	99
Adams	1	0	0	1	0	0	0	0	0	0	0	1
Asotin	3	9	8	2	3	0	0	0	0	0	0	0
Columbia	0	0	0	0	0	0	0	0	0	0	0	0
Ferry	0	0	2	0	0	0	0	0	1	0	0	0
Garfield	0	0	0	0	1	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0
Okanogan	5	3	5	1	0	2	1	0	1	2	0	1
Pend Oreille	2	0	1	0	0	1	0	0	0	0	0	0
Spokane	114	73	42	25	14	13	5	2	1	2	7	5
Stevens	1	5	1	0	0	0	0	0	0	0	0	0
Walla Walla	2	4	3	2	2	1	2	4	0	0	3	0
Whitman	0	1	4	1	1	0	1	0	0	0	0	0
TOTAL	128	95	66	32	21	17	9	6	3	4	10	7

Table 4. Pregnancies (including abortions and births) among women 15-17 years of age by county of residence, AIDSNET Region 1, 1985-1998.

COUNTY	YEAR													
	85	86	87	88	89	90	91	92	93	94	95	96	97	98
Adams	23	21	18	14	14	23	2	26	25	20	18	24	35	30
Asotin	28	18	12	12	16	21	17	15	27	18	21	17	29	20
Columbia	4	4	1	6	1	2	6	6	2	3	5	4	4	1
Ferry	9	7	8	7	8	9	8	8	8	4	4	5	11	7
Garfield	5	2	1	1	1	0	1	1	2	0	1	0	0	3
Lincoln	7	5	7	4	1	8	6	5	5	7	7	7	5	8
Okanogan	35	62	47	52	40	45	67	45	45	37	63	50	43	48
Pend Oreille	13	11	13	14	18	14	12	11	13	14	17	11	11	15
Spokane	377	425	407	377	378	378	378	361	424	403	400	380	339	306
Stevens	38	33	34	30	33	25	25	28	31	41	35	38	33	28
Walla Walla	56	51	48	60	36	51	58	57	64	70	77	66	51	60
Whitman	15	20	11	12	11	18	12	4	11	13	14	12	10	7
TOTAL	610	659	607	589	557	594	592	567	657	630	662	614	571	533

AIDSNET REGION 2

HIV/AIDS EPIDEMIOLOGIC PROFILE

Update 2001

**Benton, Chelan, Douglas, Franklin, Grant,
Kittitas, Klickitat, and Yakima Counties**



**Assessment Unit
Infectious Disease and Reproductive Health**

HIV/AIDS Epidemiologic Profile AIDSNET Region 2 – Update 2001

Purpose

The purpose of this report is to give people involved in HIV prevention community planning in Region 2 updated information related to HIV/AIDS and other related surrogate markers. Although it contains much of the data necessary for the decision-making process, it is not all-inclusive, and does not contain information from all possible data sources, definitions of terms, and information about data sources. It is recommended that readers consult the **1998 AIDSNET Region 2 HIV/AIDS Epidemiologic Profile** for further information.

What's new?

Nationally, the rates of decline in AIDS incidence and deaths resulting from the impact of highly active antiretroviral therapy slowed during the latter part of 1998 and 1999. This "stalling" of the trends appears to be taking place at the local level as well. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. At the same time, AIDS prevalence has been increasing, although the rate of increase has slowed. Prolonged health and survival of those who have been diagnosed with AIDS has brought about new challenges in prevention.

In terms of data collection, the biggest change was the initiation of HIV reporting in September, 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were demonstrated, in part, by the AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. The strengths and limitations of these data are described further in the HIV section. Additionally, initiation of HIV surveillance may have been another contributing factor to the increase in AIDS case reporting due to enhanced lab-based reporting and increased attention to surveillance in general.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although seroprevalence rates and case numbers had been decreasing in men who have sex with men (MSM), there is some evidence that these populations are experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color. Optimism about treatment successes may have brought about complacency, but HAART is no substitute for primary prevention. As new recommendations come out to

delay therapy in those who are HIV+, the strategy of “treatment as prevention” may not apply, and the focus needs to return to behavior change.

The year 2000 also brought about renewed focus on prevention in those who are HIV+. The Center for Disease Control’s HIV Prevention Strategic Plan prioritizes people living with HIV as a population to reach in order to reduce the number of new infections. The goal is to increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition. The Institute of Medicine recognized in its report, “No Time to Lose,” that those who are HIV-infected are in “a unique position to stop the spread of HIV.”

Demographic characteristics of Region 2

Table 1 presents some of the demographic characteristics of Region 2, including both the 1990 census figures and the 2000 estimates (2000 census data are not yet available). Comparison of the distribution of the general population and the distribution of those with HIV/AIDS allows for identification of populations that are overrepresented in the epidemic.

Table 1. Characteristics of the AIDSNET Region 2 Population, 1990 and 2000

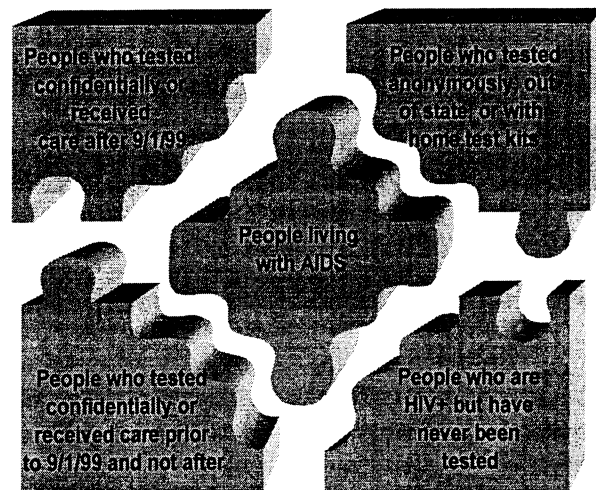
	1990 Census	2000 Census (est.)
Total population, Region 2	515,410	617,258
% of Washington State population	11%	11%
County population (% of Region 2)		
Benton	112,560 (22%)	140,377 (23%)
Chelan	52,250 (10%)	63,369 (10%)
Douglas	26,205 (5%)	31,935 (5%)
Franklin	37,473 (7%)	45,398 (7%)
Grant	54,758 (11%)	70,700 (11%)
Kittitas	26,725 (5%)	32,250 (5%)
Klickitat	16,616 (3%)	19,175 (3%)
Yakima	188,823 (37%)	214,054 (35%)
Gender		
Female	258,463 (50%)	310,345 (50%)
Male	256,947 (50%)	306,913 (50%)
Race/Ethnicity		
White	409,792 (80%)	435,558 (71%)
Black	4,977 (1%)	6,029 (1%)
Hispanic	83,568 (16%)	152,477 (25%)
Asian	6,379 (1%)	10,737 (2%)
American Indian/Alaska Native	10,694 (2%)	12,457 (2%)
Age		
<=14	130,710 (25%)	153,558 (25%)
15-19	39,051 (8%)	48,921 (8%)
20-29	72,191 (14%)	72,788 (12%)
30-39	82,152 (16%)	86,886 (14%)
40-49	63,190 (12%)	91,886 (15%)
50-59	43,329 (8%)	68,124 (11%)
60+	84,787 (16%)	95,095 (15%)

Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.

HIV data

Preliminary HIV data from Region 2 include HIV cases reported to DOH through 12/31/2000. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 1. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Region 2
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.

- Are not representative of all HIV-infected individuals. As can be seen in **Figure 1**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Preliminary data for Region 2 are presented in **Table 2**. HIV cases have been reported from all counties in Region 2 except Kittitas and Klickitat Counties. The year of diagnosis (earliest available positive test result) ranges from 1984 to 2000. When compared to recently diagnosed AIDS cases, the HIV cases include a higher proportion of women and, consequently, a higher proportion of cases due to heterosexual transmission. HIV cases also include a higher proportion of cases due to injection drug use. Both recently diagnosed AIDS cases and HIV cases include a higher proportion of cases with no identified risk (NIR), primarily because these cases were more recently diagnosed and may not know their risk factors or may not have shared the information with a provider. Additionally, many HIV cases are identified through laboratory reporting, so risk is more difficult to ascertain. In terms of age, the age of HIV diagnosis is younger than the age of AIDS diagnosis, as expected, so a higher proportion of cases is under the age of 30.

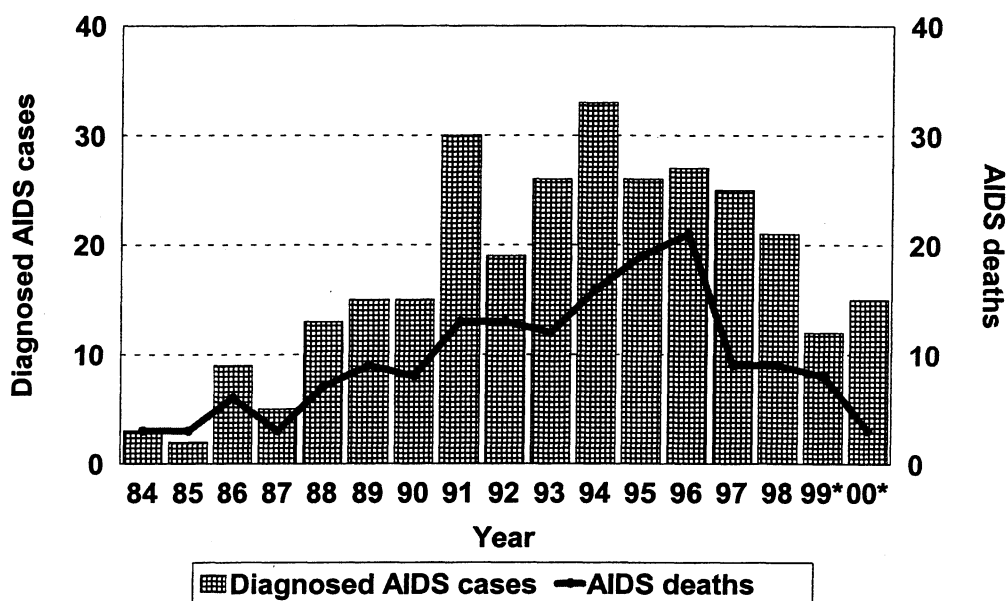
Table 2. HIV infection reported for Region 2 (As of 12/31/2000)
N = 66

County		
	Benton	10 (15%)
	Chelan	8 (12%)
	Douglas	2 (3%)
	Franklin	9 (14%)
	Grant	4 (6%)
	Kittitas	0 (0%)
	Klickitat	0 (0%)
	Yakima	33 (50%)
Year of diagnosis		
	1984-1989	13 (20%)
	1990-1995	20 (30%)
	96	5 (8%)
	97	6 (9%)
	98	4 (6%)
	99	13 (20%)
	00	5 (8%)
Gender		
	Male	45 (68%)
	Female	21 (32%)
Race/Ethnicity		
	White	40 (61%)
	Black	4 (6%)
	Hispanic	21 (32%)
	Asian/Pacific Islander	0 (0%)
	American Indian/Alaska Native	0 (0%)
	Unknown	1 (2%)
Mode of exposure		
	MSM	26 (39%)
	IDU	12 (18%)
	MSM/IDU	7 (11%)
	Heterosexual	10 (15%)
	Receipt of blood products	3 (5%)
	Other/Unknown	8 (12%)
Age		
	<13	2 (3%)
	13-19	6 (9%)
	20-29	25 (38%)
	30-39	24 (36%)
	40-49	6 (9%)
	50-59	3 (5%)
	60+	0 (0%)
Disease status		
	Asymptomatic HIV	38 (58%)
	Symptomatic HIV	28 (42%)

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 2** demonstrates the significant declines in AIDS incidence and deaths in Region 2 experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies. While AIDS deaths continue to decline, it appears that AIDS incidence has increased in 2000. This may reflect the “stalling” of the trend that has been demonstrated in other regions and at the national level.

Figure 2. AIDS cases by year of diagnosis and AIDS deaths, AIDSNET Region 2, 1984 – 2000 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The decline in HIV-related mortality has led to an increase in AIDS prevalence. As can be seen in **Figure 3**, the number of people living with AIDS in Region 2 has been increasing, adding to the challenge of providing prevention and care services.

Figure 3. Number of people living with AIDS, AIDSNET Region 2 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete.)

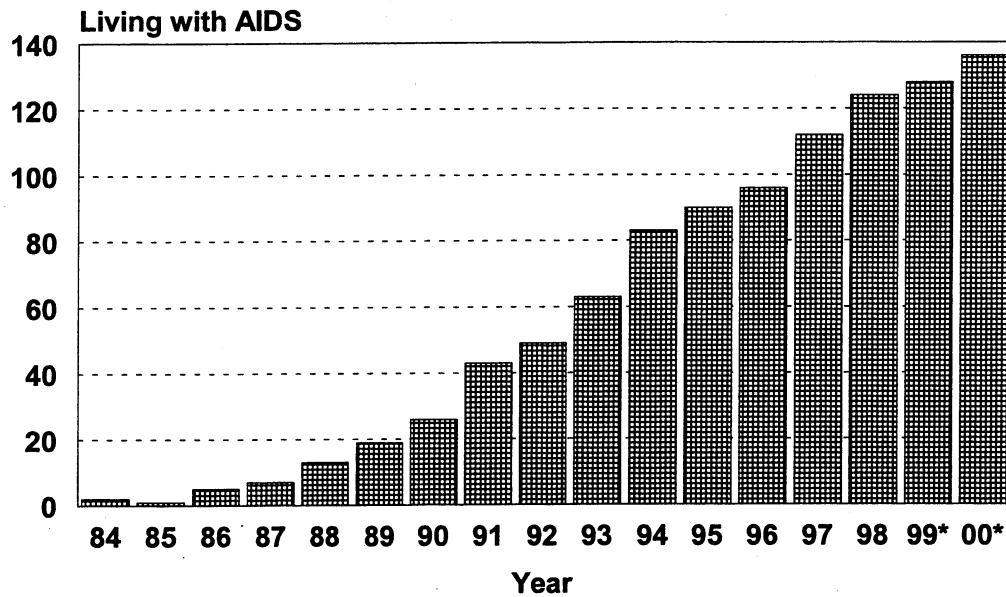


Table 3 describes the changes in the distribution of AIDS cases over time in Region 2. AIDS cases have included an increasing proportion of women, cases due heterosexual transmission, and cases in those who are Hispanic.

Table 3. AIDS case trends over three time periods, AIDSNET Region 2

	Year of diagnosis		
	1985-1989 n = 44	1990-1994 n = 123	1995-1999 n = 111
Gender			
Male	93%	85%	86%
Female	7%	15%	14%
Mode of exposure			
MSM	57%	53%	47%
IDU	14%	14%	12%
MSM/IDU	25%	11%	8%
Heterosexual	0%	10%	18%
Receipt of blood products	5%	2%	3%
Other/Unknown	0%	10%	13%
Race/Ethnicity			
White	77%	68%	62%
Black	5%	5%	4%
Hispanic	16%	24%	34%
Asian/Pacific Islander	0%	1%	0%
American Indian/Alaska Native	2%	2%	0%
Unknown	0%	0%	0%
Age			
<13	0%	1%	1%
13-19	2%	2%	1%
20-29	16%	27%	25%
30-39	43%	38%	40%
40-49	36%	22%	18%
50-59	2%	7%	13%
60+	0%	4%	3%

HIV/AIDS in behaviorally-defined populations

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of AIDS cases. In Region 2, 50% of those living with AIDS were men exposed through sex with other men (this does not include MSM who also inject drugs). Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Region 2.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories by gender, race/ethnicity, and region of residence for the 135 adults and adolescents living with AIDS who were diagnosed in Region 2.

In looking at these tables, it is important to note that although MSM account for the majority of Region 2 AIDS cases (both in Yakima County and outside of Yakima County), cases among other HIV exposure categories have occurred and are of particular significance among women and persons of color (Tables 4-6).

Table 4. Adults and adolescents living with AIDS, by HIV exposure category and sex, AIDSNET Region 2. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Region 2 Total
Men who have sex with men (MSM)	68 (60%)		68 (50%)
Female and heterosexual male injection drug users	10 (9%)	5 (24%)	15 (11%)
MSM who use injection drugs	12 (11%)		12 (9%)
Heterosexual contacts*	8 (7%)	12 (57%)	20 (15%)
Receipt of blood products	2 (2%)	0 (0%)	2 (1%)
Other/unknown	14 (12%)	4 (19%)	18 (13%)
TOTAL	114	21	135

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 5. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, AIDSNET Region 2. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	46 (59%)	1 (25%)	20 (40%)	1 (100%)	0 (0%)
Female and heterosexual male injection drug users	10 (13%)	2 (50%)	3 (6%)	0 (0%)	0 (0%)
MSM who use injection drugs	6 (8%)	0 (0%)	5 (10%)	0 (0%)	1 (50%)
Heterosexual contacts*	8 (10%)	1 (25%)	11 (22%)	0 (0%)	0 (0%)
Receipt of blood products	2 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other/unknown	6 (8%)	0 (0%)	11 (22%)	0 (0%)	1 (50%)
TOTAL	78	4	50	1	2

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 6. Adults and adolescents living with AIDS, by exposure category and residence at AIDS diagnosis, AIDSNET Region 2. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 still not considered to be complete).

HIV Exposure Category	Non-Yakima County	Yakima County	Region 2 Total
Men who have sex with men	31 (42%)	37 (60%)	68 (50%)
Female and heterosexual male injection drug users	8 (11%)	7 (11%)	15 (11%)
MSM who use injection drugs	7 (10%)	5 (8%)	12 (9%)
Heterosexual contacts*	11 (15%)	9 (15%)	20 (15%)
Receipt of blood products	2 (3%)	0 (0%)	2 (1%)
Other/unknown	14 (19%)	4 (6%)	18 (13%)
TOTAL	73	62	135

Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Figure 4. Proportion of AIDS cases accounted for by selected HIV exposure groups, AIDSNET Region 2, 1989-2000. (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)

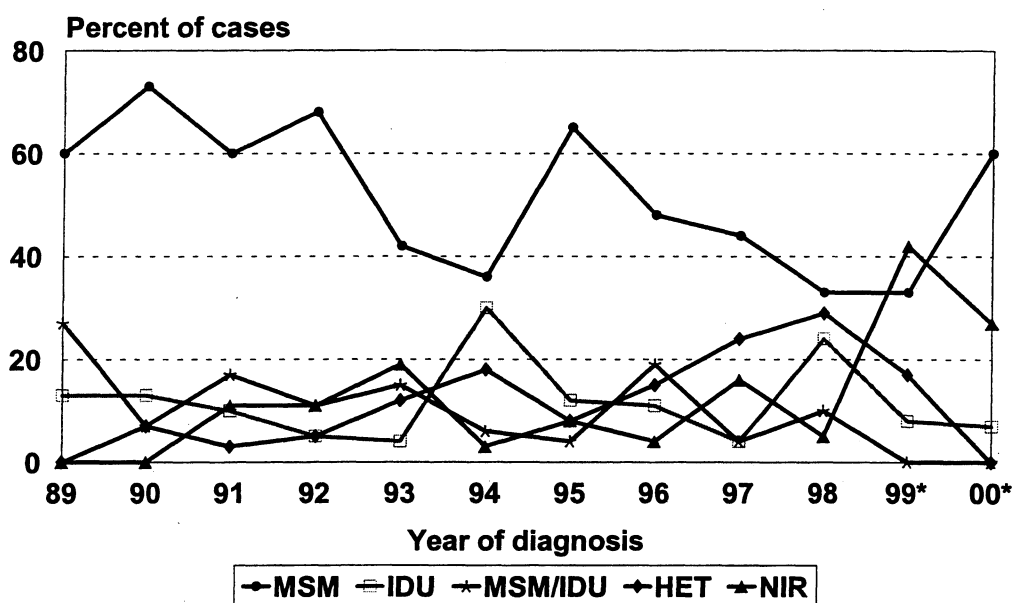


Figure 4 shows that the proportion of AIDS cases attributable to MSM has been showing a declining trend overall (proportions may vary greatly year to year due to small numbers). The increase in proportions of cases due to injection drug use and heterosexual transmission have been small but steady over time. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

HIV/AIDS in demographically-defined populations

A. Adolescents and young adults

AIDS cases and trends

AIDS cases in persons 13-29 years of age reflect HIV transmission which occurred during adolescence or early adulthood. Of the 298 AIDS cases diagnosed in Region 2 between 1983 and 2000, 80 (27%) have been among persons 13-29 years of age. Two percent of all cases have been diagnosed among persons 13-19 years of age; 25% have been diagnosed among persons 20-29 years of age. Although the number of AIDS cases among persons 13-19 years of age has been relatively stable, cases among persons 20-29 years of age increased through the mid-1990s appear to have leveled out (**Figure 5**).

Since the majority of AIDS cases in this age category are attributable to MSM, this trend may in part reflect the statewide trends in MSM.

All modes of HIV exposure have been reported among adolescents and young adults in Region 2 (Table 7). Twenty-two cases in 13-24 year olds have been diagnosed in males (76%), and seven cases (24%) have been diagnosed in females. The majority of cases (34%) have been reported among young men who have had sex with men, with an additional three cases (10%) due to MSM and injection drug use.

Figure 5. AIDS cases among adolescents and young adults by year of diagnosis, AIDSNET Region 2, 1984-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*).

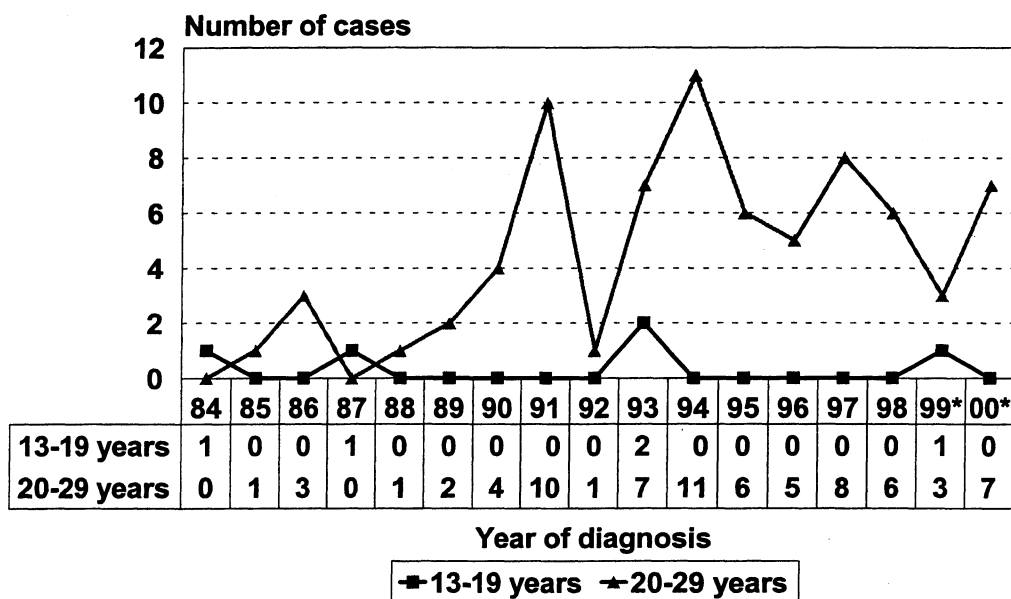


Table 7. Mode of HIV exposure among adolescents and young adults (13-24 years), AIDSNET Region 2, 1983-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

Exposure category	Number (%)
Men who have sex with men (MSM)	10 (34%)
Female and heterosexual male injection drug user	3 (10%)
MSM who used injection drugs	3 (10%)
Heterosexual contact*	6 (21%)
Receipt of blood products	3 (10%)
Not reported/unknown	4 (14%)
TOTAL	29

*Heterosexual contact with a person with HIV or known to be at risk for HIV.

B. People of color

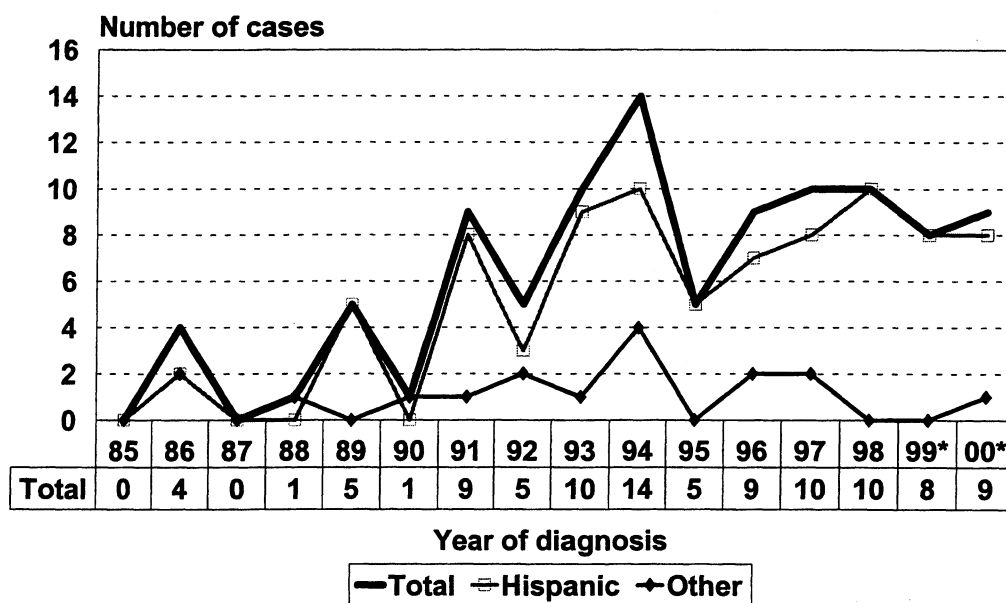
Although transmission of HIV results from certain high risk behaviors and is not the result of one's race or ethnicity, racial and ethnic minorities have been disproportionately affected by the HIV epidemic and, therefore, will be considered separately.

AIDS cases and trends

A total of 100 AIDS cases have been diagnosed between 1983 and 2000 among people of color who were residents of Region 2 at the time of diagnosis. These cases account for 34% of the AIDS cases from this region.

The majority of cases (83 cases, or 83%) among people of color in Region 2 were Hispanic; 46 (55%) were from Yakima and 37 (45%) were from counties outside of Yakima. The number of cases among people of color increased through 1994, and appears to have stabilized in the last few years (**Figure 6**). Since the numbers of cases are small, trends must be interpreted with caution. Of the 100 cases diagnosed in Region 2 among people of color, more than half (51) have been diagnosed since 1995.

Figure 6. AIDS cases among people of color, AIDSNET Region 2, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*.)



C. Women

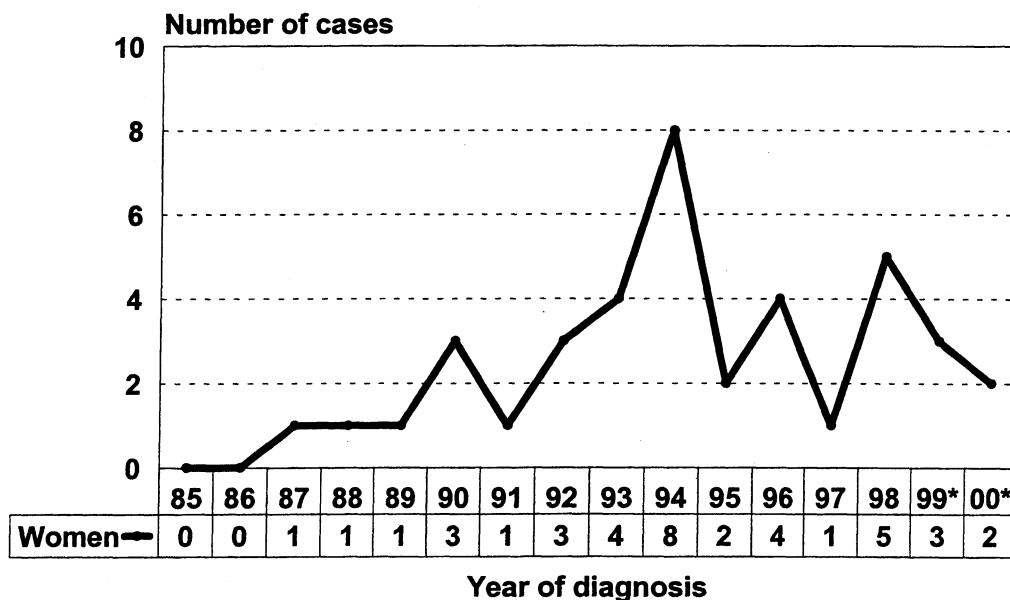
Women, as a general group, are not at increased risk for HIV. However, specific prevention programs can be targeted toward women (e.g., AZT during pregnancy); furthermore, the proportion of cases among women seems to be increasing as a result of increasing cases among injection drug users and their heterosexual partners. As a result, data on women are presented as a separate section.

AIDS cases and trends

From 1983-2000, 39 cases of AIDS were reported among women (≥ 13 years of age) who were residents of Region 2 at the time of diagnosis. The cases among women accounted for 13% of all Region 2 AIDS cases.

The number of AIDS cases among women in Region 2 increased through 1994 and now appears to be leveling out (trends must be interpreted with caution due to small numbers) (**Figure 7**). Women have been making up an increasing proportion of AIDS cases in Region 2 (**Table 3**).

Figure 7. AIDS cases among women by year of diagnosis, AIDSNET Region 2, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).



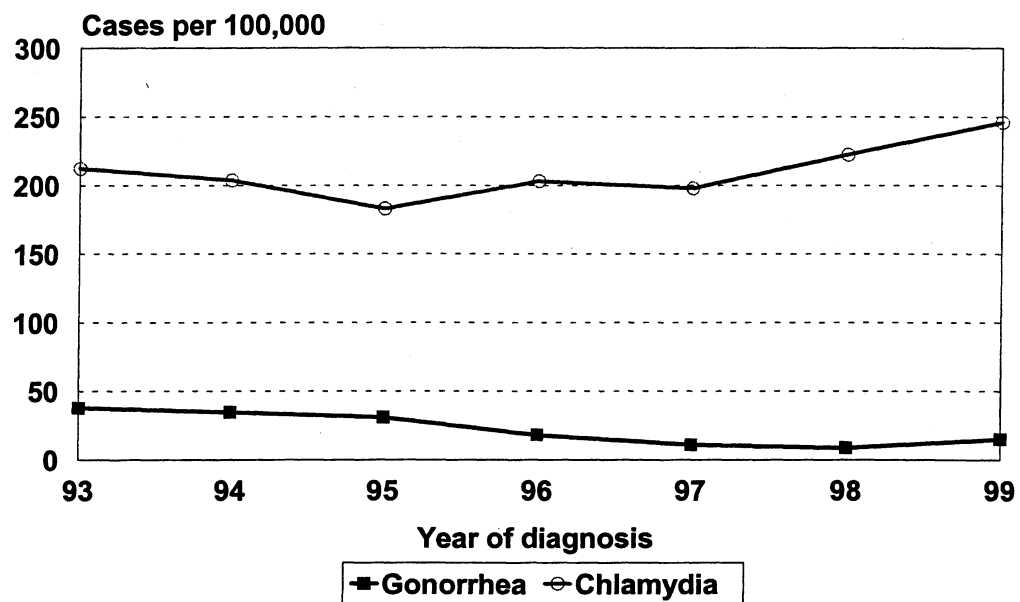
Of the 39 cumulative cases among women, 20 (51%) were white, four (4%) were Black, 14 (36%) were Hispanic, and one (3%) was American Indian/Alaska Native.

The majority of women cumulatively diagnosed with AIDS in Region 2 (19 cases or 49%) acquired HIV from heterosexual contact with a person with HIV or known to be at risk for HIV; 11 cases (28%) occurred among female injection drug users. Of the 19 cases resulting from heterosexual contact, nine (23%) were due to heterosexual contact with someone with HIV/AIDS (exposure risk unknown), 5 (13%) were due to heterosexual contact with an injection drug user, four (10%) were due to heterosexual contact with a bisexual male, and two (6%) were due to heterosexual contact with a recipient of blood products. The number of cases among women was too small to identify any differences in HIV exposure by race/ethnicity.

Surrogate indicators

In addition to HIV and AIDS-related data, it is important to consider other sources of data that may indicate risk behavior. **Figure 8 and Tables 2-4 in the Appendix** describe some of these surrogate indicators. Chlamydia case rates have increased in the past few years, while gonorrhea rates have been decreasing. STD case rates are higher in people of color and people who are younger. Teen pregnancy rates have been stable. Hepatitis B cases have been declining over time and are a less useful indicator of risk behavior due, in part, to the availability of a vaccine. Chronic hepatitis C became reportable in December 2000, and data related to this indicator will provide information about certain at-risk populations in the future.

Figure 8. Chlamydia and gonorrhea case rates for Region 2, 1993 – 1999.



APPENDIX

Table 1. AIDS cases by county of residence at diagnosis, AIDSNET Region 2, 1983-2000 (Cases reported as of December 31, 2000)*

COUNTY	YEAR																TOTAL	LIVING**
	<=85	86	87	88	89	90	91	92	93	94	95	96	97	98	99*	00*		
Benton	0	1	0	6	3	4	4	7	3	7	4	8	10	3	2	3	65	37
Chelan	1	1	1	0	1	4	4	2	6	1	4	0	4	0	1	1	31	12
Douglas	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	2	0
Franklin	0	0	0	1	2	0	2	0	0	1	2	1	2	6	2	3	22	12
Grant	1	0	0	1	2	1	6	2	3	6	2	0	0	0	1	0	25	6
Kittitas	1	2	0	1	0	1	1	2	0	0	1	1	2	1	0	0	13	5
Klickitat	0	0	0	0	1	1	2	1	3	0	1	0	0	1	0	0	10	2
Yakima	4	5	4	3	6	4	10	5	11	18	12	17	7	10	6	8	130	62
TOTAL	7	9	5	13	15	15	30	19	26	33	26	27	25	21	12	15	298	136

*Due to delays in reporting, case counts for 1999 and 2000 are still not considered complete.

**Based on known deaths as of September 30, 2000.

Table 2. Cases of gonorrhea by county of residence at diagnosis, AIDSNET Region 2, 1982-1999.

COUNTY	YEAR																	
	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
Benton	160	177	157	183	171	171	100	48	32	19	17	11	13	27	15	9	6	13
Chelan	111	108	96	81	79	91	87	47	48	14	19	11	17	12	6	2	8	4
Douglas	34	42	17	19	23	19	32	21	20	4	17	4	5	2	6	1	0	2
Franklin	92	102	116	150	210	201	150	74	73	17	15	11	10	32	20	12	6	6
Grant	66	93	60	61	58	44	42	16	15	24	12	5	5	20	15	12	3	9
Kittitas	28	25	14	16	26	14	11	10	2	8	6	0	2	4	2	1	0	2
Klickitat	11	16	7	12	20	4	9	2	2	1	0	1	0	2	0	0	0	1
Yakima	786	733	870	818	1141	1136	699	618	301	271	162	166	146	82	43	28	30	55
TOTAL	1288	1296	1337	1340	1728	1680	1130	836	493	358	248	209	198	181	107	65	53	92

Table 3. Cases of hepatitis B by county of residence at time of diagnosis, AIDSNET Region 2, 1988-1999.

COUNTY	YEAR														
	88	89	90	91	92	93	94	95	96	97	98	99			
Benton	28	30	18	8	11	1	5	4	4	5	5	6			
Chelan	29	19	16	6	7	1	7	2	1	0	0	0			
Douglas	2	2	4	1	3	0	2	1	0	0	0	0			
Franklin	23	23	11	3	3	4	4	5	1	1	2	2			
Grant	9	11	4	3	2	1	2	2	0	0	0	1			
Kittitas	1	6	2	0	2	4	1	1	0	0	0	0			
Klickitat	4	3	2	0	0	1	0	2	0	0	1	0			
Yakima	84	74	34	15	11	10	8	6	3	6	9	6			
TOTAL	180	168	91	36	39	22	29	23	9	12	17	15			

Table 4. Pregnancies (including abortions and births) among women 15-17 years of age by county of residence, AIDSNET Region 2, 1985-1998.

COUNTY	YEAR													
	85	86	87	88	89	90	91	92	93	94	95	96	97	98
Benton	133	131	140	127	115	104	122	148	137	163	154	136	152	129
Chelan	65	75	67	59	65	56	59	97	76	67	70	70	66	68
Douglas	23	20	40	26	31	36	27	33	37	20	26	30	26	30
Franklin	57	69	70	70	71	74	100	97	99	94	91	113	87	92
Grant	66	77	75	71	64	64	84	97	88	86	102	109	127	86
Kittitas	21	16	19	21	21	15	17	20	17	17	9	19	20	26
Klickitat	10	17	24	10	21	15	17	24	20	19	14	19	20	16
Yakima	324	318	337	334	351	357	380	417	403	391	416	390	400	370
TOTAL	699	723	772	718	739	721	806	933	877	857	882	886	898	817

AIDSNET REGION 3

HIV/AIDS EPIDEMIOLOGIC PROFILE

Update 2001

**Island, San Juan, Skagit,
Snohomish, and Whatcom Counties**



**Assessment Unit
Infectious Disease and Reproductive Health**

HIV/AIDS Epidemiologic Profile AIDSNET Region 3 – Update 2001

Purpose

The purpose of this report is to give people involved in HIV prevention community planning in Region 3 updated information related to HIV/AIDS and other related surrogate markers. Although it contains much of the data necessary for the decision-making process, it is not all-inclusive, and does not contain information from all possible data sources, definitions of terms, and information about data sources. It is recommended that readers consult the **1998 AIDSNET Region 3 HIV/AIDS Epidemiologic Profile** for further information.

What's new?

Nationally, the rates of decline in AIDS incidence and deaths resulting from the impact of highly active antiretroviral therapy slowed during the latter part of 1998 and 1999. This "stalling" of the trends appears to be taking place at the local level as well. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. At the same time, AIDS prevalence has been increasing, although the rate of increase has slowed. Prolonged health and survival of those who have been diagnosed with AIDS has brought about new challenges in prevention.

In terms of data collection, the biggest change was the initiation of HIV reporting in September, 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were demonstrated, in part, by the AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. The strengths and limitations of these data are described further in the HIV section. Additionally, initiation of HIV surveillance may have been another contributing factor to the increase in AIDS case reporting due to enhanced lab-based reporting and increased attention to surveillance in general.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although seroprevalence rates and case numbers had been decreasing in men who have sex with men (MSM), there is some evidence that these populations are experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color. Optimism about treatment successes may have brought about complacency, but HAART is no substitute for primary prevention. As new recommendations come out to

delay therapy in those who are HIV+, the strategy of “treatment as prevention” may not apply, and the focus needs to return to behavior change.

The year 2000 also brought about renewed focus on prevention in those who are HIV+. The Center for Disease Control’s HIV Prevention Strategic Plan prioritizes people living with HIV as a population to reach in order to reduce the number of new infections. The goal is to increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition. The Institute of Medicine recognized in its report, “No Time to Lose,” that those who are HIV-infected are in “a unique position to stop the spread of HIV.”

Demographic characteristics of Region 3

Table 1 presents some of the demographic characteristics of Region 3, including both the 1990 census figures and the 2000 estimates (2000 census data are not yet available). Comparison of the distribution of the general population and the distribution of those with HIV/AIDS allows for identification of populations that are overrepresented in the epidemic.

Table 1. Characteristics of the AIDSNET Region 3 Population, 1990 and 2000

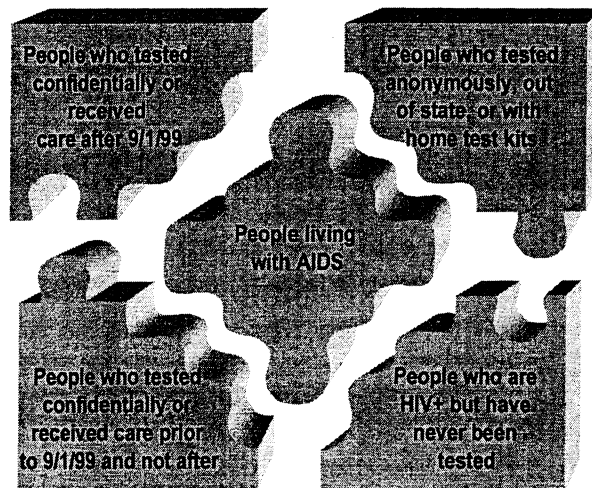
	1990 Census	2000 Census (est.)
Total population, Region 3	743, 207	942,527
% of Washington State population	15%	16%
County population (% of Region 3)		
Island	60,195 (8%)	74,196 (8%)
San Juan	10,035 (1%)	12,745 (1%)
Skagit	79,555 (11%)	100,988 (11%)
Snohomish	465,642 (63%)	592,133 (63%)
Whatcom	127,780 (17%)	162,465 (17%)
Gender		
Female	372,731 (50%)	472,148 (50%)
Male	370,476 (50%)	470,379 (50%)
Race/Ethnicity		
White	681,813 (92%)	840,379 (89%)
Black	6,977 (1%)	11,005 (1%)
Hispanic	20,829 (3%)	35,545 (4%)
Asian	21,478 (3%)	40,017 (4%)
American Indian/Alaska Native	12,110 (2%)	15,581 (2%)
Age		
<=14	172,571 (23%)	215,643 (23%)
15-19	47,777 (6%)	67,027 (7%)
20-29	115,318 (16%)	114,827 (12%)
30-39	136,254 (18%)	144,713 (15%)
40-49	100,054 (13%)	154,270 (16%)
50-59	60,326 (8%)	108,539 (12%)
60+	110,907 (15%)	137,508 (15%)

Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.

HIV data

Preliminary HIV data from Region 3 include HIV cases reported to DOH through 12/31/2000. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 1. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Region 3
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.

- Are not representative of all HIV-infected individuals. As can be seen in **Figure 1**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Preliminary data for Region 3 are presented in **Table 2**. HIV cases have been reported from all counties in Region 3. The year of diagnosis (earliest available positive test result) ranges from 1984 to 2000. When compared to recently diagnosed AIDS cases, the HIV cases include a higher proportion of women and, consequently, a higher proportion of cases due to heterosexual transmission. HIV cases also include a higher proportion of cases with no identified risk, primarily because these cases are earlier in the course of infection and may not know their risk factors or may not have shared the information with a provider. Additionally, many HIV cases are identified through laboratory reporting, so risk is more difficult to ascertain. In terms of age, the age of HIV diagnosis is younger than the age of AIDS diagnosis, as expected, so a higher proportion of cases is under the age of 30.

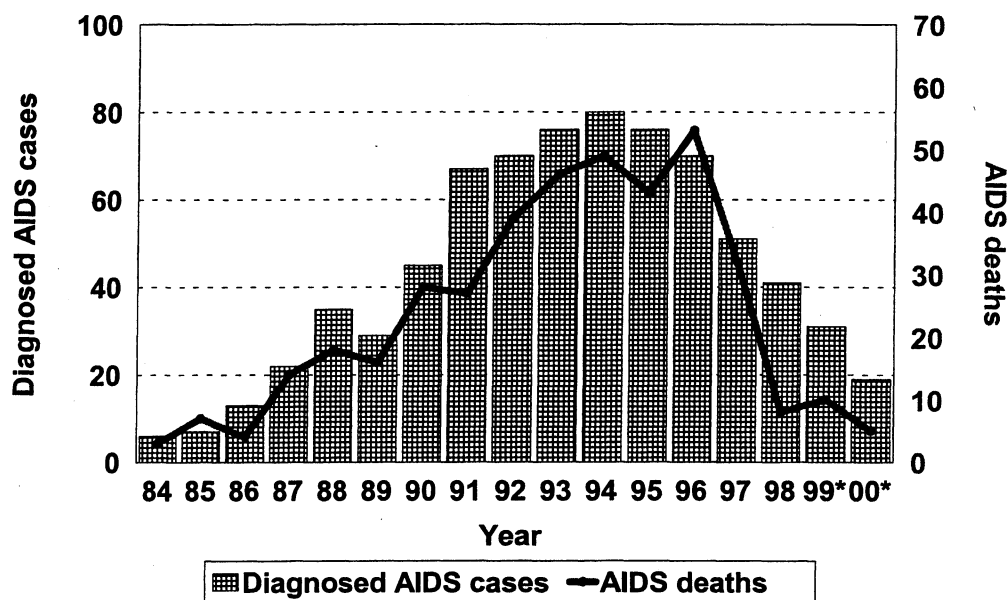
Table 2. HIV infection reported for Region 3 (As of 12/31/2000)
N = 171

County		
	Island	7 (4%)
	San Juan	2 (1%)
	Skagit	14 (8%)
	Snohomish	123 (72%)
	Whatcom	25 (15%)
Year of diagnosis		
	1984-1989	23 (13%)
	1990-1995	70 (41%)
	96	19 (11%)
	97	19 (11%)
	98	7 (4%)
	99	19 (11%)
	00	14 (8%)
Gender		
	Male	132 (77%)
	Female	39 (23%)
Race/Ethnicity		
	White	142 (83%)
	Black	12 (7%)
	Hispanic	6 (4%)
	Asian/Pacific Islander	6 (4%)
	American Indian/Alaska Native	5 (3%)
	Unknown	0 (0%)
Mode of exposure		
	MSM	83 (49%)
	IDU	23 (13%)
	MSM/IDU	13 (8%)
	Heterosexual	27 (16%)
	Receipt of blood products	1 (1%)
	Other/Unknown	24 (14%)
Age		
	<13	4 (2%)
	13-19	6 (4%)
	20-29	57 (33%)
	30-39	65 (38%)
	40-49	29 (17%)
	50-59	10 (6%)
	60+	0 (0%)
Disease status		
	Asymptomatic HIV	123 (72%)
	Symptomatic HIV	48 (28%)

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 2** demonstrates the significant declines in AIDS incidence and deaths in Region 3 experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies. Since data are incomplete for 1999 and 2000, it may be too early to ascertain if the “stalling” of these trends will be demonstrated.

Figure 2. AIDS cases by year of diagnosis and AIDS deaths, AIDSNET Region 3, 1984 – 2000 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The decline in HIV-related mortality has led to an increase in AIDS prevalence. As can be seen in **Figure 3**, the number of people living with AIDS in Region 3 has been increasing, adding to the challenge of providing prevention and care services.

Figure 3. Number of people living with AIDS, AIDSNET Region 3 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete.)

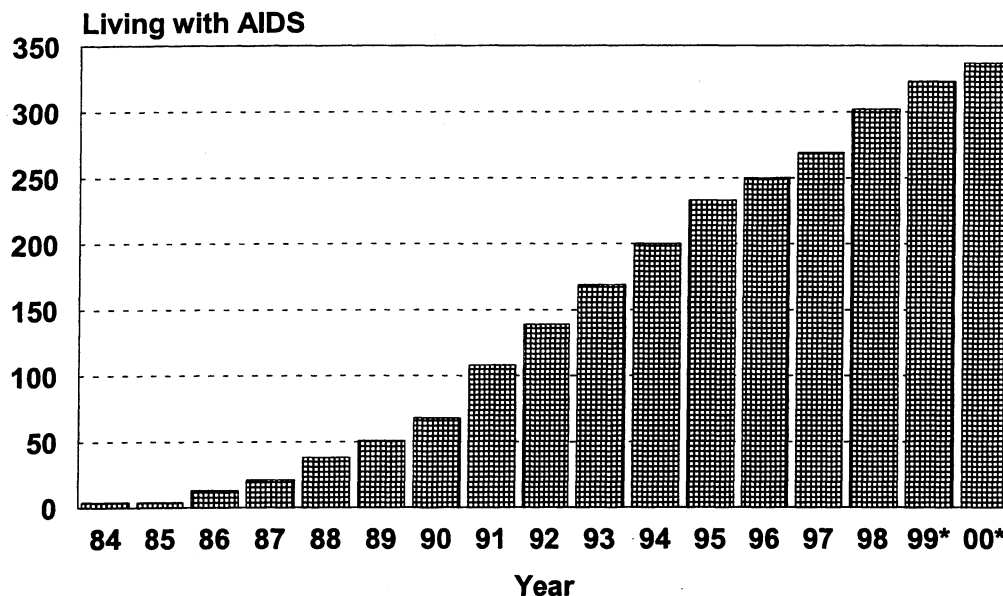


Table 3 describes the changes in the distribution of AIDS cases over time in Region 3. AIDS cases have included an increasing proportion of women, cases due to injection drug use and heterosexual transmission, and people of color, particularly Blacks and American Indian/Alaska Natives.

Table 3. AIDS case trends over three time periods, AIDSNET Region 3

	Year of diagnosis		
	1985-1989 n = 106	1990-1994 n = 338	1995-1999 n = 269
Gender			
Male	93%	89%	83%
Female	7%	11%	17%
Mode of exposure			
MSM	71%	62%	48%
IDU	5%	12%	13%
MSM/IDU	15%	11%	8%
Heterosexual	2%	7%	15%
Receipt of blood products	4%	3%	4%
Other/Unknown	4%	5%	14%
Race/Ethnicity			
White	92%	86%	81%
Black	3%	4%	7%
Hispanic	3%	6%	4%
Asian/Pacific Islander	0%	2%	3%
American Indian/Alaska Native	2%	2%	5%
Unknown	0%	0%	<1%
Age			
<13	3%	<1%	0%
13-19	0%	<1%	1%
20-29	17%	20%	16%
30-39	46%	41%	44%
40-49	20%	31%	28%
50-59	9%	4%	7%
60+	5%	3%	4%

HIV/AIDS in behaviorally-defined populations

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of AIDS cases. In Region 3, 53% of those living with AIDS were men exposed through sex with other men (this does not include MSM who also inject drugs). Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Region 3.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories by gender, race/ethnicity, and region of residence for the 337 adults and adolescents living with AIDS who were diagnosed in Region 3.

In looking at these tables, it is important to note that although MSM account for the majority of Region 3 AIDS cases (both in Snohomish County and outside of Snohomish County), cases among other HIV exposure categories have occurred and are of particular significance among women and persons of color (Tables 4-6).

Table 4. Adults and adolescents living with AIDS, by HIV exposure category and sex, AIDSNET Region 3. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Region 3 Total
Men who have sex with men (MSM)	179 (63%)		179 (53%)
Female and heterosexual male injection drug users	24 (9%)	9 (16%)	33 (10%)
MSM who use injection drugs	30 (11%)		30 (9%)
Heterosexual contacts*	12 (4%)	36 (65%)	48 (14%)
Receipt of blood products	9 (3%)	2 (4%)	11 (3%)
Other/unknown	28 (10%)	8 (15%)	36 (11%)
TOTAL	282	55	337

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 5. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, AIDSNET Region 3. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	157 (57%)	9 (45%)	7 (35%)	2 (25%)	4 (33%)
Female and heterosexual male injection drug users	25 (9%)	3 (15%)	1 (5%)	0 (0%)	4 (33%)
MSM who use injection drugs	23 (8%)	1 (5%)	2 (10%)	0 (0%)	4 (33%)
Heterosexual contacts*	40 (14%)	2 (10%)	3 (15%)	3 (38%)	0 (0%)
Receipt of blood products	8 (3%)	0 (0%)	2 (10%)	1 (13%)	0 (0%)
Other/unknown	24 (9%)	5 (25%)	5 (25%)	2 (25%)	0 (0%)
TOTAL	277	20	20	8	12

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 6. Adults and adolescents living with AIDS, by exposure category and residence at AIDS diagnosis, AIDSNET Region 3. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 still not considered to be complete).

HIV Exposure Category	Snohomish County	Non-Snohomish County	Region 3 Total
Men who have sex with men	12 (53%)	57 (54%)	179 (53%)
Female and heterosexual male injection drug users	22 (10%)	11 (10%)	33 (10%)
MSM who use injection drugs	19 (8%)	11 (10%)	30 (9%)
Heterosexual contacts*	34 (15%)	14 (13%)	48 (14%)
Receipt of blood products	9 (4%)	2 (2%)	11 (3%)
Other/unknown	25 (11%)	11 (10%)	36 (11%)
TOTAL	231	106	337

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Figure 4. Proportion of AIDS cases accounted for by selected HIV exposure groups, AIDSNET Region 3, 1989-2000. (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)

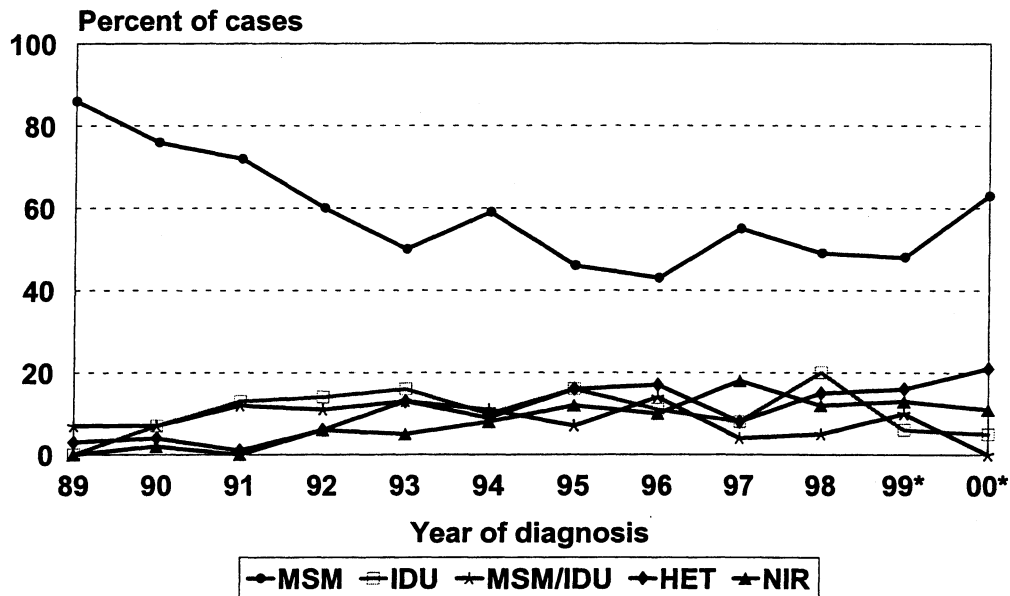


Figure 4 shows that the proportion of AIDS cases attributable to MSM decreased gradually through 1996, and appears to have stabilized and even increased slightly in 2000. The increase in proportions of cases due to injection drug use and heterosexual transmission have been small but steady over time. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

HIV/AIDS in demographically-defined populations

A. Adolescents and young adults

AIDS cases and trends

AIDS cases in persons 13-29 years of age reflect HIV transmission which occurred during adolescence or early adulthood. Of the 739 AIDS cases diagnosed in Region 3 between 1983 and 2000, 133 (18%) have been among persons 13-29 years of age. Less than 1% of all cases have been diagnosed among persons 13-19 years of age; over 17% have been diagnosed among persons 20-29 years of age. Although the number of AIDS cases among persons 13-19 years of age has been relatively stable, cases among persons 20-29 years of age increased in 1989-1990, decreased in the mid-1990s, and then appear to

have leveled out (**Figure 5**). Since the majority of AIDS cases in this age category are attributable to MSM, this trend may in part reflect the statewide trends in white MSM.

All modes of HIV exposure have been reported among adolescents and young adults in Region 3 (**Table 7**). Seventeen cases in 13-24 year olds have been diagnosed in males (68%), and eight cases (32%) have been diagnosed in females. The majority of cases (36%) have been reported among young men who have had sex with men, with an additional four cases (16%) due to MSM and injection drug use.

Figure 5. AIDS cases among adolescents and young adults by year of diagnosis, AIDSNET Region 3, 1984-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*).

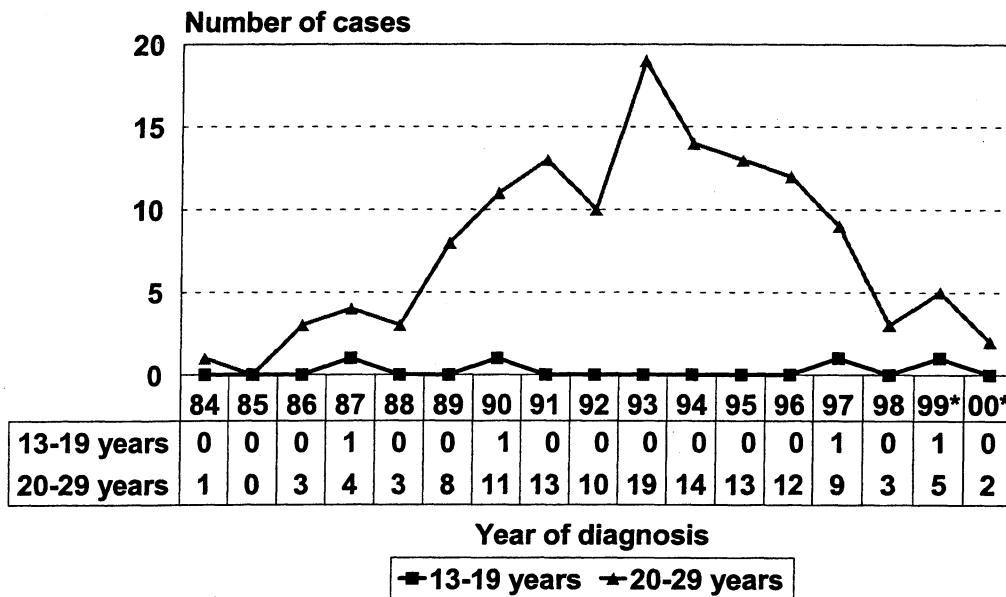


Table 7. Mode of HIV exposure among adolescents and young adults (13-24 years), AIDSNET Region 3, 1983-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

Exposure category	Number (%)
Men who have sex with men (MSM)	9 (36%)
Female and heterosexual male injection drug user	1 (4%)
MSM who used injection drugs	4 (16%)
Heterosexual contact*	5 (20%)
Receipt of blood products	3 (12%)
Not reported/unknown	3 (12%)
TOTAL	25

*Heterosexual contact with a person with HIV or known to be at risk for HIV.

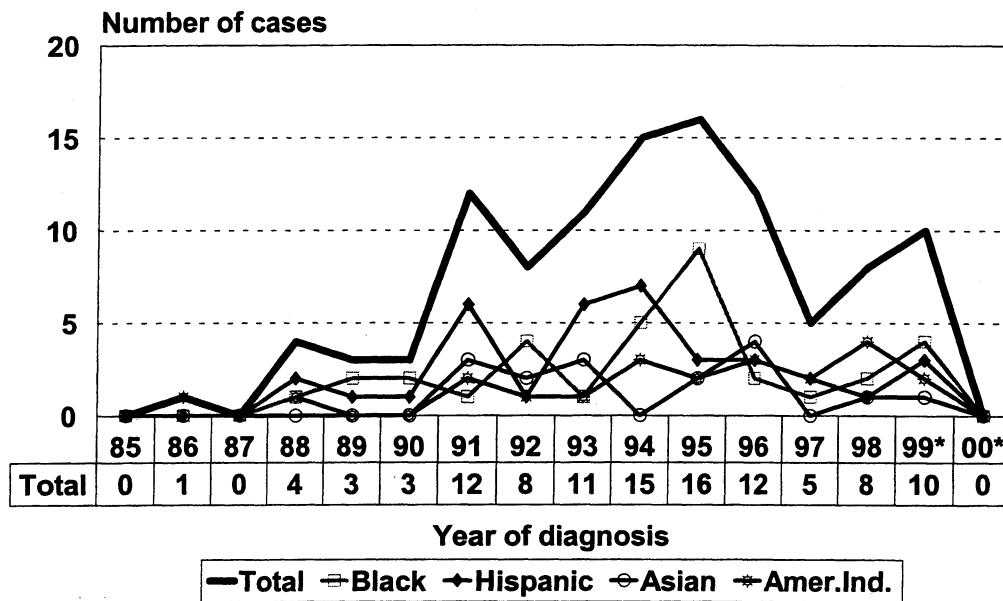
B. People of color

Although transmission of HIV results from certain high risk behaviors and is not the result of one's race or ethnicity, racial and ethnic minorities have been disproportionately affected by the HIV epidemic and, therefore, will be considered separately.

AIDS cases and trends

A total of 109 AIDS cases have been diagnosed between 1983 and 2000 among people of color who were residents of Region 3 at the time of diagnosis. These cases account for 15% of the AIDS cases from this region. The number of cases among people of color increased through 1996, then declined, and appears to have increased in the last few years (**Figure 6**). Since the numbers of cases are small, trends must be interpreted with caution. Of the 109 cases diagnosed in Region 3 among people of color, almost half (51) have been diagnosed since 1995.

Figure 6. AIDS cases among people of color, AIDSNET Region 3, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*)



C. Women

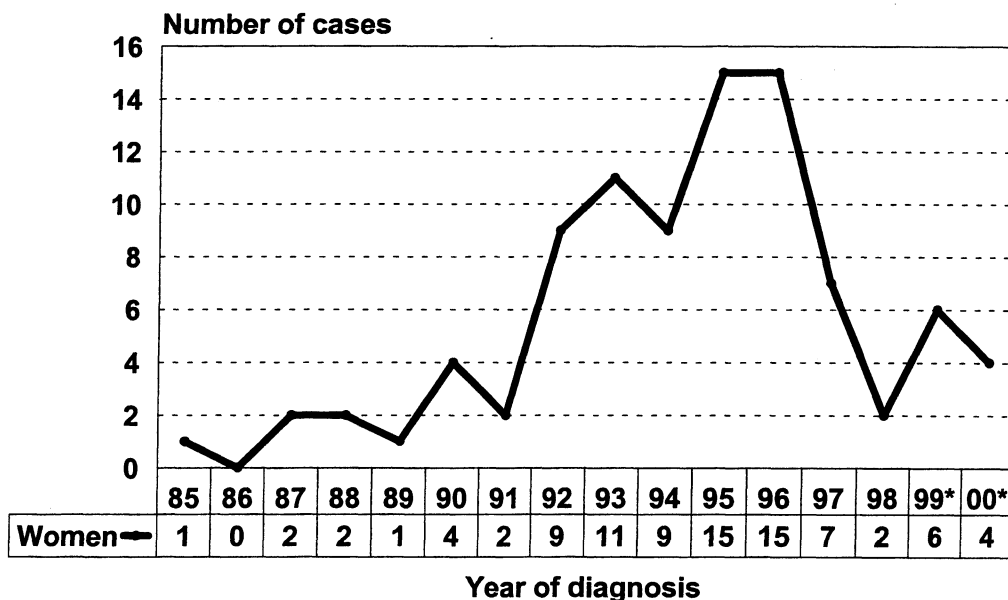
Women, as a general group, are not at increased risk for HIV. However, specific prevention programs can be targeted toward women (e.g., AZT during pregnancy); furthermore, the proportion of cases among women seems to be increasing as a result of increasing cases among injection drug users and their heterosexual partners. As a result, data on women are presented as a separate section.

AIDS cases and trends

From 1983-2000, 90 cases of AIDS were reported among women (≥ 13 years of age) who were residents of Region 3 at the time of diagnosis. The cases among women accounted for 12% of all Region 3 AIDS cases.

The number of AIDS cases among women in Region 3 declined through 1998 and now appears to be leveling out (trends must be interpreted with caution due to small numbers) (Figure 7). Women have been making up an increasing proportion of AIDS cases in Region 3 (Table 3).

Figure 7. AIDS cases among women by year of diagnosis, AIDSNET Region 3, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).



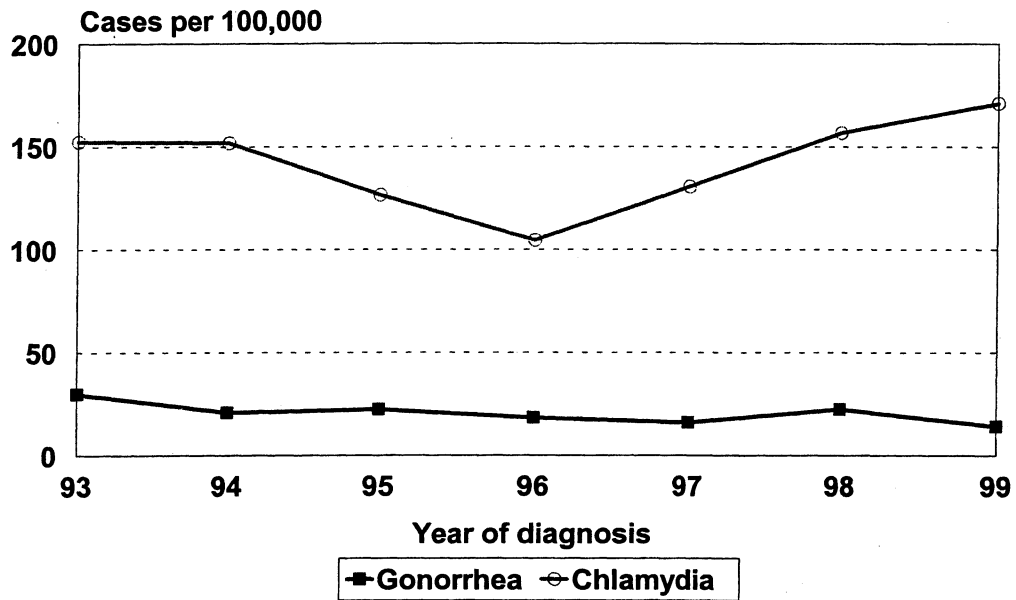
Of the 90 cumulative cases among women, 70 (78%) were white, six (7%) were Black, six (7%) were Hispanic, five (6%) were Asian/Pacific Islander and three (3%) were American Indian/Alaska Native.

The majority of women living with AIDS in Region 3 (36 cases or 65%) acquired HIV from heterosexual contact with a person with HIV or known to be at risk for HIV (**Table 4**); nine cases occurred among female injection drug users. Of the 36 cases resulting from heterosexual contact, 20 (56%) were due to heterosexual contact with someone with HIV/AIDS (exposure risk unknown), 14 (39%) were due to heterosexual contact with an injection drug user, one (3%) was due to heterosexual contact with a bisexual male, and one (3%) was due to heterosexual contact with a hemophiliac. The number of cases among women was too small to identify any differences in HIV exposure by race/ethnicity.

Surrogate indicators

In addition to HIV and AIDS-related data, it is important to consider other sources of data that may indicate risk behavior. **Figure 8 and Tables 2-4 in the Appendix** describe some of these surrogate indicators. Chlamydia case rates have increased in the past few years, while gonorrhea rates have remained relatively stable. STD case rates are higher in people of color and people who are younger. Teen pregnancy rates have been stable. Hepatitis B cases have been declining over time and are a less useful indicator of risk behavior due, in part, to the availability of a vaccine. Chronic hepatitis C became reportable in December 2000, and data related to this indicator will provide information about certain at-risk populations in the future.

Figure 8. Chlamydia and gonorrhea case rates for Region 3, 1993 – 1999.



APPENDIX

Table 1. AIDS cases by county of residence at diagnosis, AIDSNET Region 3, 1983-2000 (Cases reported as of December 31, 2000.*)

COUNTY	YEAR																TOTAL LIVING**	
	<=85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00		
Island	0	1	1	0	3	3	6	4	7	9	3	5	4	1	2	1	51	18
San Juan	3	1	0	2	0	2	1	1	0	0	2	1	1	0	2	0	16	6
Skagit	1	0	1	3	0	8	4	7	3	3	6	5	1	1	1	1	45	18
Snohomish	8	11	14	23	18	24	49	47	56	52	53	41	36	28	18	17	494	231
Whatcom	2	0	6	7	8	8	7	11	10	16	12	18	9	11	8	0	133	64
TOTAL	14	13	22	35	29	45	67	70	76	80	76	70	51	41	31	19	739	337

*Due to delays in reporting, case counts for 1999 and 2000 are still not considered complete.

**Based on known deaths as of September 30, 2000.

Table 2. Cases of gonorrhea by county of residence at diagnosis, AIDSNET Region 3, 1982-1999.

COUNTY	YEAR																	
	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
Island	38	15	11	7	6	18	9	15	5	15	23	22	10	27	10	3	21	8
San Juan	9	1	2	0	1	1	0	0	0	2	0	0	1	0	1	0	1	0
Skagit	105	129	117	82	46	66	61	26	19	66	18	15	5	9	18	9	20	12
Snohomish	536	444	429	443	440	403	261	231	186	166	159	166	116	110	107	117	150	91
Whatcom	244	145	124	156	85	91	46	28	28	39	24	40	42	42	23	12	12	20
TOTAL	932	734	683	688	578	579	377	300	238	288	224	243	174	191	159	141	204	131

Table 3. Cases of hepatitis B by county of residence at time of diagnosis, AIDSNET Region 3, 1988-1999.

COUNTY	YEAR											
	88	89	90	91	92	93	94	95	96	97	98	99
Island	2	0	3	1	1	0	0	1	0	0	1	0
San Juan	1	0	0	2	1	0	1	0	0	0	0	0
Skagit	6	30	10	4	3	5	1	2	6	5	2	2
Snohomish	55	71	56	36	38	13	23	15	11	7	15	8
Whatcom	25	32	12	15	6	2	5	1	0	3	0	4
TOTAL	89	133	81	58	49	20	30	19	17	15	18	14

Table 4. Pregnancies (including abortions and births) among women 15-17 years of age by county of residence, AIDSNET Region 3, 1985-1998.

COUNTY	YEAR													
	85	86	87	88	89	90	91	92	93	94	95	96	97	98
Island	38	28	39	42	41	43	39	55	40	40	47	42	45	62
San Juan	3	3	6	4	4	9	4	5	5	7	2	1	6	5
Skagit	72	83	85	80	82	92	100	107	107	97	92	111	109	113
Snohomish	367	407	496	435	469	468	440	460	501	471	464	493	469	486
Whatcom	99	99	100	110	95	114	105	129	115	123	117	122	136	132
TOTAL	579	620	726	671	691	726	688	756	768	738	722	769	765	798

AIDSNET REGION 4

HIV/AIDS EPIDEMIOLOGIC PROFILE

Update 2001

King County



**Assessment Unit
Infectious Disease and Reproductive Health**

HIV/AIDS Epidemiologic Profile AIDSNET Region 4 – Update 2001

Purpose

The purpose of this report is to give people involved in HIV prevention community planning in Region 4 updated information related to HIV/AIDS and other related surrogate markers. Staff in Region 4 produce an epidemiologic profile and fact sheets to be used in planning processes; this document is being provided so that data are in a format comparable to the data provided for other AIDSNet regions. As with the other regional profiles, although it contains much of the data necessary for the decision-making process, it is not all-inclusive, and does not contain information from all possible data sources, definitions of terms, and information about data sources. It is recommended that readers also consult the **HIV/AIDS Epidemiology Profile for Community Planning** that is produced by Public Health – Seattle & King County.

What's new?

Nationally, the rates of decline in AIDS incidence and deaths resulting from the impact of highly active antiretroviral therapy slowed during the latter part of 1998 and 1999. This “stalling” of the trends appears to be taking place at the local level as well. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. At the same time, AIDS prevalence has been increasing, although the rate of increase has slowed. Prolonged health and survival of those who have been diagnosed with AIDS has brought about new challenges in prevention.

In terms of data collection, the biggest change was the initiation of HIV reporting in September, 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were demonstrated, in part, by the AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. The strengths and limitations of these data are described further in the HIV section. Additionally, initiation of HIV surveillance may have been another contributing factor to the increase in AIDS case reporting due to enhanced lab-based reporting and increased attention to surveillance in general.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although seroprevalence rates and case numbers had been decreasing in men who have sex with men (MSM), there is some evidence that these populations are experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected

anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color. Optimism about treatment successes may have brought about complacency, but HAART is no substitute for primary prevention. As new recommendations come out to delay therapy in those who are HIV+, the strategy of “treatment as prevention” may not apply, and the focus needs to return to behavior change.

The year 2000 also brought about renewed focus on prevention in those who are HIV+. The Center for Disease Control’s HIV Prevention Strategic Plan prioritizes people living with HIV as a population to reach in order to reduce the number of new infections. The goal is to increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition. The Institute of Medicine recognized in its report, “No Time to Lose,” that those who are HIV-infected are in “a unique position to stop the spread of HIV.”

Demographic characteristics of Region 4

Table 1 presents some of the demographic characteristics of Region 4, including both the 1990 census figures and the 2000 estimates (2000 census data are not yet available). Comparison of the distribution of the general population and the distribution of those with HIV/AIDS allows for identification of populations that are overrepresented in the epidemic.

Table 1. Characteristics of the AIDSNET Region 4 Population, 1990 and 2000

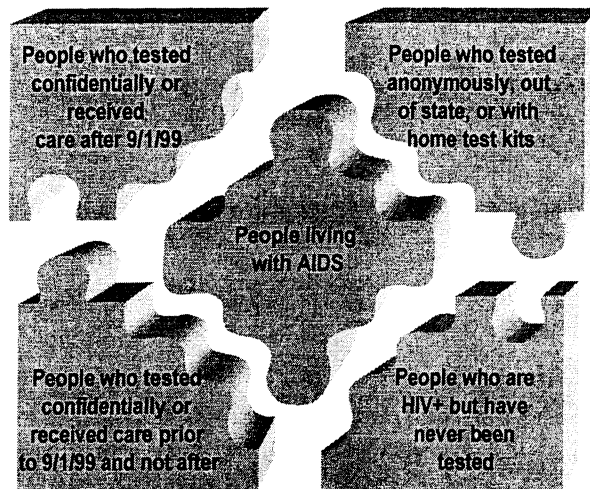
	1990 Census	2000 Census (est.)
Total population, Region 4	1,507,319	1,704,217
% of Washington State population	31%	29%
Gender		
Female	764,718 (51%)	857,978 (50%)
Male	742,601 (49%)	846,239 (50%)
Race/Ethnicity		
White	1,256,380 (83%)	1,358,660 (80%)
Black	74,849 (5%)	91,775 (5%)
Hispanic	44,322 (3%)	61,143 (4%)
Asian	115,810 (8%)	173,340 (10%)
American Indian/Alaska Native	15,958 (1%)	19,299 (1%)
Age		
<=14	292,497 (19%)	344,883 (20%)
15-19	88,670 (6%)	108,999 (6%)
20-29	260,639 (17%)	209,057 (12%)
30-39	297,689 (20%)	289,663 (17%)
40-49	218,551 (14%)	307,762 (18%)
50-59	126,883 (8%)	202,653 (12%)
60+	222,390 (15%)	241,200 (14%)

Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.

HIV data

Preliminary HIV data from Region 4 include HIV cases reported to DOH through 12/31/2000. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 1. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Region 4
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.
- Are not representative of all HIV-infected individuals. As can be seen in **Figure 1**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics.

There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Preliminary data for Region 4 are presented in **Table 2**. The year of diagnosis (earliest available positive test result) ranges from 1982 to 2000. When compared to recently diagnosed AIDS cases, the HIV cases include a higher proportion of women. HIV cases also include a higher proportion of cases with no identified risk, primarily because these cases are earlier in the course of infection and may not know their risk factors or may not have shared the information with a provider. Additionally, many HIV cases are identified through laboratory reporting, so risk is more difficult to ascertain. In terms of age, the age of HIV diagnosis is younger than the age of AIDS diagnosis, as expected, so a higher proportion of cases is under the age of 30.

Table 2. HIV infection reported for Region 4 (As of 12/31/2000)
N = 1,334

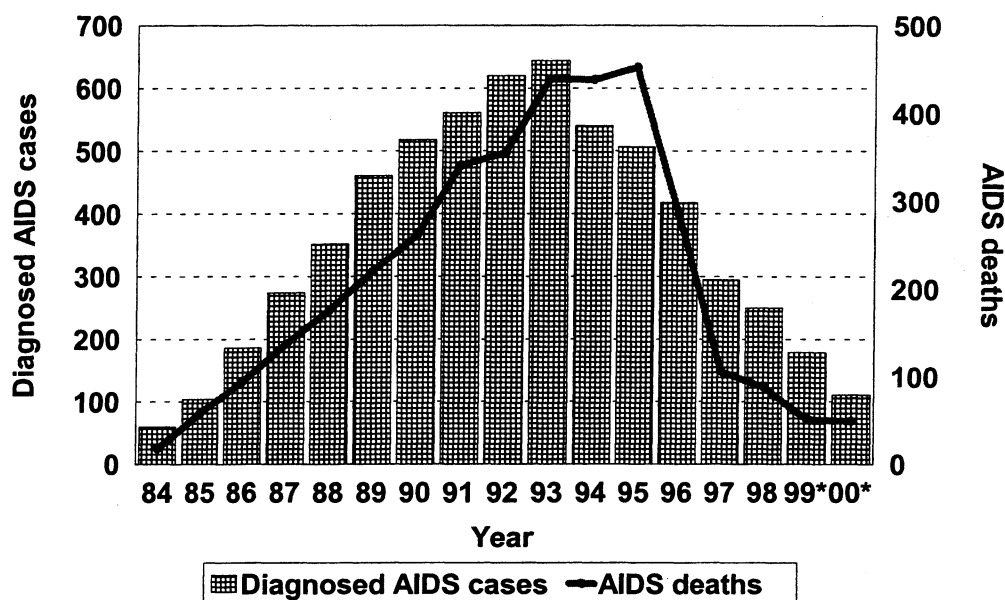
County		
	King	1,334 (100%)
Year of diagnosis		
	1982-1989	239 (18%)
	1990-1995	480 (36%)
	96	90 (7%)
	97	109 (8%)
	98	109 (8%)
	99	156 (12%)
	00	151 (11%)
Gender		
	Male	1,168 (88%)
	Female	166 (12%)
Race/Ethnicity		
	White	982 (74%)
	Black	198 (15%)
	Hispanic	100 (8%)
	Asian/Pacific Islander	26 (2%)
	American Indian/Alaska Native	22 (2%)
	Unknown	6 (<1%)
Mode of exposure		
	MSM	893 (67%)
	IDU	100 (8%)
	MSM/IDU	143 (11%)
	Heterosexual	57 (4%)
	Receipt of blood products	10 (1%)
	Other/Unknown	131 (10%)
Age		
	<13	16 (1%)
	13-19	41 (3%)
	20-29	452 (34%)
	30-39	557 (42%)
	40-49	217 (16%)
	50-59	45 (3%)
	60+	6 (<1%)
Disease status		
	Asymptomatic HIV	857 (64%)
	Symptomatic HIV	477 (36%)

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 2** demonstrates the significant declines in AIDS incidence and

deaths in Region 4 experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies.

Figure 2. AIDS cases by year of diagnosis and AIDS deaths, AIDSNET Region 4, 1984 – 2000 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The decline in HIV-related mortality has lead to an increase in AIDS prevalence. As can bee seen in **Figure 3**, the number of people living with AIDS in Region 4 has been increasing, adding to the challenge of providing prevention and care services.

Figure 3. Number of people living with AIDS, AIDSNET Region 4 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete.)

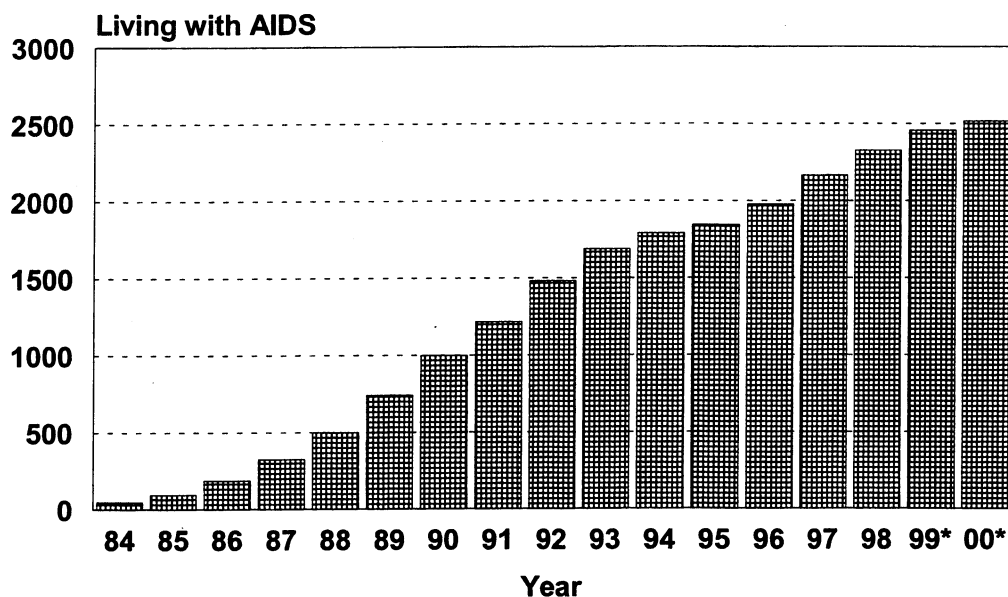


Table 3 describes the changes in the distribution of AIDS cases over time in Region 4. AIDS cases have included an increasing proportion of women, cases due to injection drug use and heterosexual transmission, and people of color, particularly Blacks and Hispanics. Additionally, the proportion of those diagnosed with AIDS who are over 40 years of age has been getting larger. This increase may be due, in part, to the ability of the new therapies to keep people from reaching an AIDS diagnosis until a later point in time.

Table 3. AIDS case trends over three time periods, AIDSNET Region 4

	Year of diagnosis		
	1985-1989 n = 1,377	1990-1994 n = 2,883	1995-1999 n = 1,649
Gender			
Male	98%	96%	92%
Female	2%	4%	8%
Mode of exposure			
MSM	81%	78%	67%
IDU	3%	5%	8%
MSM/IDU	11%	11%	9%
Heterosexual	1%	3%	5%
Receipt of blood products	2%	1%	1%
Other/Unknown	1%	2%	10%
Race/Ethnicity			
White	87%	82%	72%
Black	7%	9%	14%
Hispanic	4%	5%	9%
Asian/Pacific Islander	2%	2%	2%
American Indian/Alaska Native	1%	1%	2%
Unknown	0%	0%	0%
Age			
<13	<1%	<1%	<1%
13-19	<1%	<1%	<1%
20-29	19%	18%	14%
30-39	49%	49%	48%
40-49	22%	26%	27%
50-59	7%	6%	8%
60+	2%	2%	2%

HIV/AIDS in behaviorally-defined populations

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of AIDS cases. In Region 4, 58% of those living with AIDS were men exposed through sex with other men. Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Region 4.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories by gender, race/ethnicity, and region of residence for the 2,512 adults and adolescents living with AIDS who were diagnosed in Region 4.

In looking at these tables, it is important to note that although MSM account for the majority of Region 4 AIDS cases, cases among other HIV exposure categories have occurred and are of particular significance among women and persons of color (Tables 4 and 5).

Table 4. Adults and adolescents living with AIDS, by HIV exposure category and sex, AIDSNET Region 4. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Region 4 Total
Men who have sex with men (MSM)	1,795 (7%)		1,795 (71%)
Female and heterosexual male injection drug users	127 (5%)	53 (32%)	180 (7%)
MSM who use injection drugs	242 (10%)		242 (10%)
Heterosexual contacts*	78 (2%)	78 (47%)	116 (5%)
Receipt of blood products	19 (1%)	5 (3%)	24 (1%)
Other/unknown	124 (5%)	31 (19%)	155 (6%)
TOTAL	2,345	167	2,512

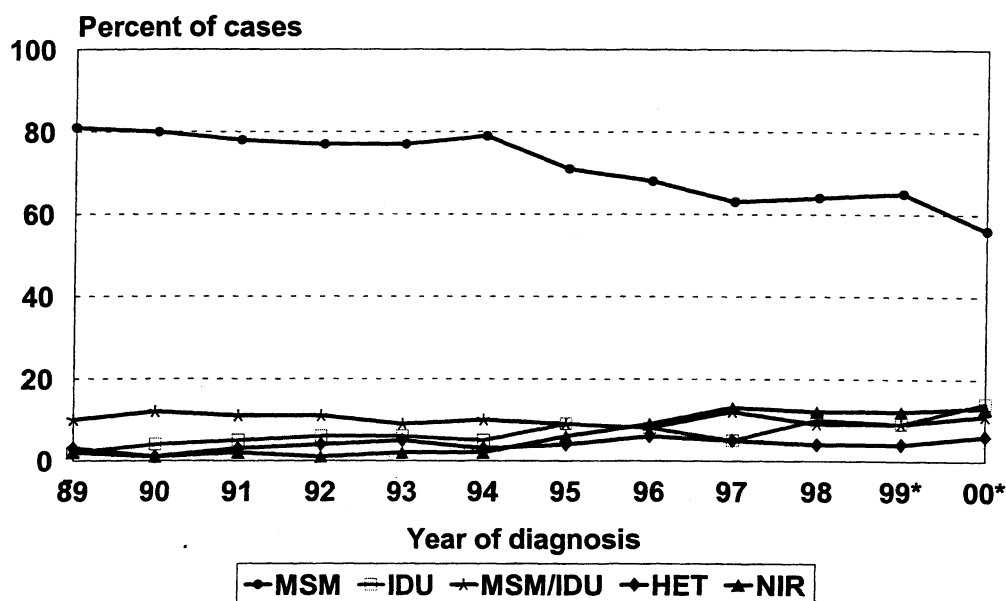
*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 5. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, AIDSNET Region 4. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	1,469 (78%)	138 (42%)	139 (65%)	34 (72%)	15 (31%)
Female and heterosexual male injection drug users	77 (4%)	61 (18%)	29 (14%)	1 (2%)	12 (25%)
MSM who use injection drugs	191 (10%)	22 (7%)	11 (5%)	1 (2%)	17 (35%)
Heterosexual contacts*	57 (3%)	41 (12%)	13 (6%)	3 (6%)	2 (4%)
Receipt of blood products	19 (1%)	2 (1%)	2 (1%)	1 (2%)	0 (0%)
Other/unknown	60 (3%)	66 (20%)	20 (9%)	7 (15%)	2 (4%)
TOTAL	1,873	330	214	47	48

*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes one person of unknown race/ethnicity.

Figure 4. Proportion of AIDS cases accounted for by selected HIV exposure groups, AIDSNET Region 4, 1989-2000. (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The proportion of AIDS cases attributable to MSM has been decreasing in Region 4 as it has in other areas of the state. **Figure 4** shows that the proportion of AIDS cases in this population has been decreasing gradually since 1990 (as a result of increases in cases in other transmission risk categories). The proportion of cases due to injection drug use has been increasing, and there has been a small but steady increase in the proportion of cases due to heterosexual transmission. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

HIV/AIDS in demographically-defined populations

A. Adolescents and young adults

AIDS cases and trends

AIDS cases in persons 13-29 years of age reflect HIV transmission which occurred during adolescence or early adulthood. Of the 6,092 AIDS cases diagnosed in Region 4 between 1982 and 2000, 1,052 (17%) have been among persons 13-29 years of age. Less than 1% of all cases have been diagnosed among persons 13-19 years of age; 17% have been diagnosed among persons 20-29 years of age. Although the number of AIDS cases

among persons 13-19 years of age has been relatively stable, cases among persons 20-29 years of age increased in 1989-1990 and then decreased in the mid-1990s (**Figure 5**). Since the majority of AIDS cases in this age category are attributable to MSM, this trend may in part reflect the statewide trends in white MSM.

All modes of HIV exposure have been reported among adolescents and young adults in Region 4 (**Table 6**). One hundred forty three cases in 13-24 year olds have been diagnosed in males (88%), and nineteen cases (12%) have been diagnosed in females. The majority of cases (58%) have been reported among young men who have had sex with men.

Figure 5. AIDS cases among adolescents and young adults by year of diagnosis, AIDSNET Region 4, 1984-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*).

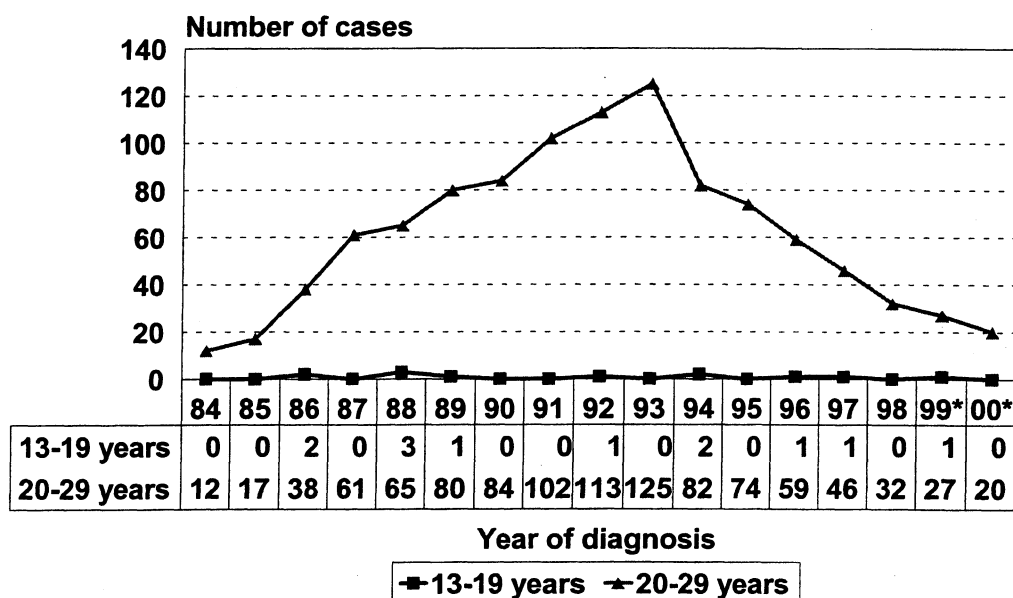


Table 6. Mode of HIV exposure among adolescents and young adults (13-24 years) by gender, AIDSNET Region 4, 1982-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

Exposure category	Number (%)
Men who have sex with men (MSM)	94 (58%)
Female and heterosexual male injection drug user	13 (8%)
MSM who used injection drugs	26 (16%)
Heterosexual contact*	11 (7%)
Receipt of blood products	8 (5%)
Not reported/unknown	10 (6%)
TOTAL	162

*Heterosexual contact with a person with HIV or known to be at risk for HIV.

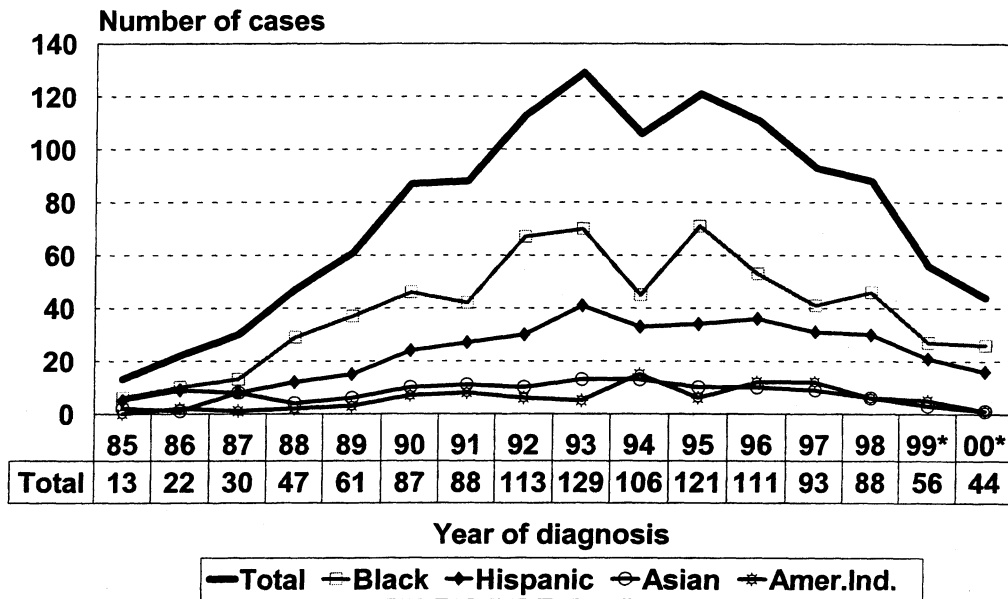
B. People of color

Although transmission of HIV results from certain high risk behaviors and is not the result of one's race or ethnicity, racial and ethnic minorities have been disproportionately affected by the HIV epidemic and, therefore, will be considered separately.

AIDS cases and trends

A total of 1,214 AIDS cases have been diagnosed between 1982 and 2000 among people of color who were residents of Region 4 at the time of diagnosis. These cases account for 20% of the AIDS cases from this region. The number of cases among people of color increased through 1993, then declined, a trend that has been seen in other groups (**Figure 6**). Of the 1,214 cases diagnosed in Region 4 among people of color, 42% have been diagnosed since 1995.

Figure 6. AIDS cases among people of color, AIDSNET Region 4, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*.)



C. Women

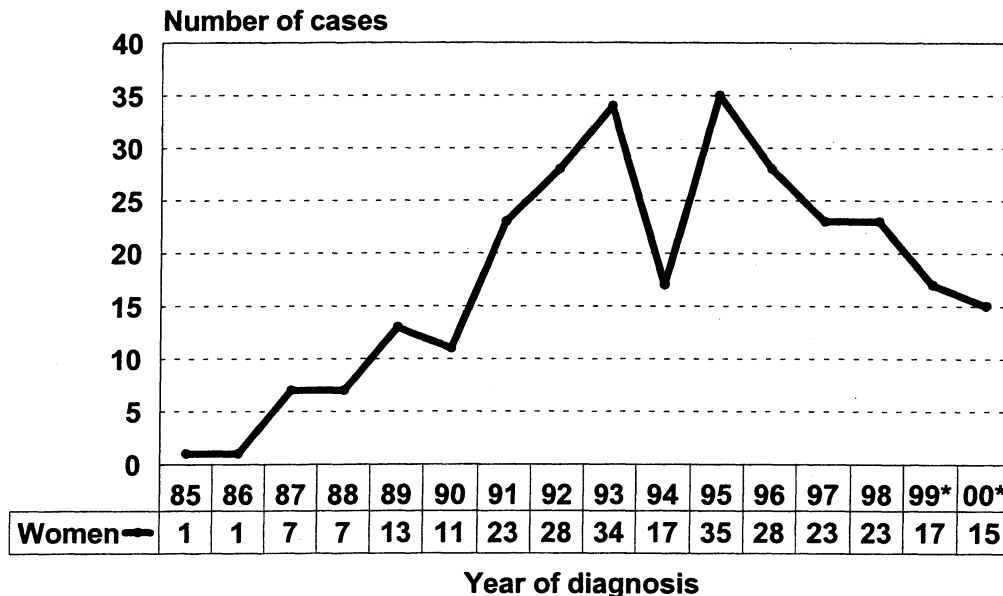
Women, as a general group, are not at increased risk for HIV. However, specific prevention programs can be targeted toward women (e.g., AZT during pregnancy); furthermore, the proportion of cases among women seems to be increasing as a result of increasing cases among injection drug users and their heterosexual partners. As a result, data on women are presented as a separate section.

AIDS cases and trends

From 1982-2000, 285 cases of AIDS were reported among women (≥ 13 years of age) who were residents of Region 4 at the time of diagnosis. The cases among women accounted for 5% of all Region 4 AIDS cases.

The number of AIDS cases among women in Region 4 increased through the mid-1990s and has decreased in recent years, as has been seen in other populations (**Figure 7**). Women have been making up an increasing proportion of AIDS cases in Region 4 (**Table 3**).

Figure 7. AIDS cases among women by year of diagnosis, AIDSNET Region 4, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).



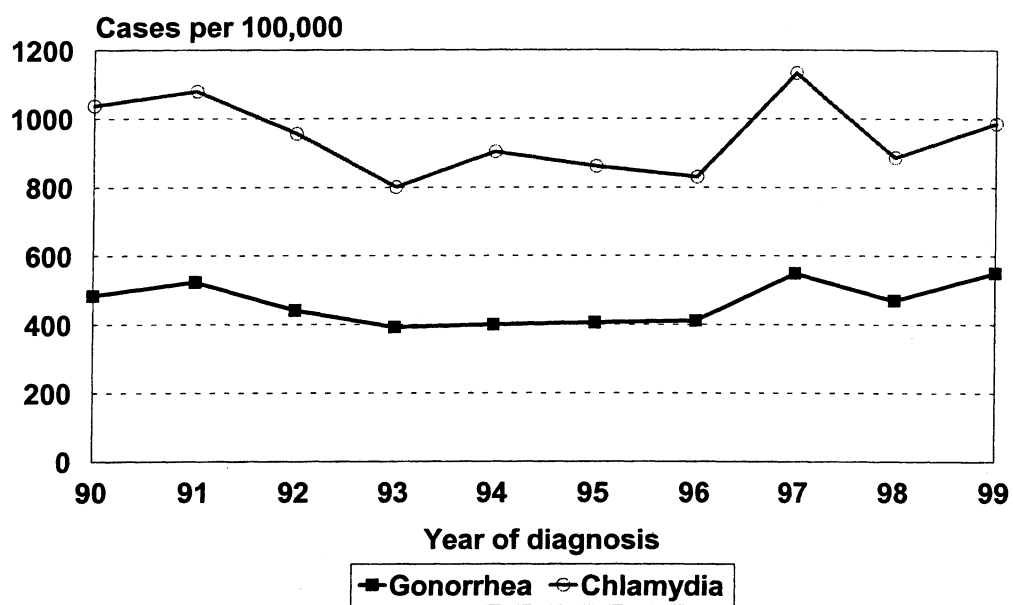
Of the 285 cases among women, 158 (55%) were white, 88 (31%) were Black, 14 (5%) were Hispanic, eight (3%) were Asian/Pacific Islander and 17 (6%) were American Indian/Alaska Native.

The majority of women living with AIDS in Region 4 (78 cases or 47%) acquired HIV from heterosexual contact with a person with HIV or known to be at risk for HIV (**Table 4**); 53 cases occurred among female injection drug users. Of the 78 cases resulting from heterosexual contact, 51(65%) were due to heterosexual contact with someone with HIV/AIDS (exposure risk unknown), 16 (21%) were due to heterosexual contact with an injection drug user, 10 (13%) were due to heterosexual contact with a bisexual male, and one (1%) was due to heterosexual contact with a hemophiliac. The number of cases among women was too small to identify any differences in HIV exposure by race/ethnicity.

Surrogate indicators

In addition to HIV and AIDS-related data, it is important to consider other sources of data that may indicate risk behavior. **Figure 8** describes some of these surrogate indicators, none of which has dramatically changed in the last few years. STD case rates have been relatively stable over time, with higher rates in people of color and people who are younger. Teen pregnancy rates have been decreasing over time. Hepatitis B cases have been declining over time and are a less useful indicator of risk behavior due, in part, to the availability of a vaccine. Chronic hepatitis C became reportable in December 2000, and data related to this indicator will provide information about certain at-risk populations in the future.

Figure 8. Chlamydia and gonorrhea case rates in 15-19 year olds, Region 4, 1990 – 1999.



AIDSNET REGION 5

HIV/AIDS EPIDEMIOLOGIC PROFILE

Update 2001

Kitsap and Pierce Counties



**Assessment Unit
Infectious Disease and Reproductive Health**

HIV/AIDS Epidemiologic Profile AIDSNET Region 5 – Update 2001

Purpose

The purpose of this report is to give people involved in HIV prevention community planning in Region 5 updated information related to HIV/AIDS and other related surrogate markers. Although it contains much of the data necessary for the decision-making process, it is not all-inclusive, and does not contain information from all possible data sources, definitions of terms, and information about data sources. It is recommended that readers consult the **1998 AIDSNET Region 5 HIV/AIDS Epidemiologic Profile** for further information.

What's new?

Nationally, the rates of decline in AIDS incidence and deaths resulting from the impact of highly active antiretroviral therapy slowed during the latter part of 1998 and 1999. This "stalling" of the trends appears to be taking place at the local level as well. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. At the same time, AIDS prevalence has been increasing, although the rate of increase has slowed. Prolonged health and survival of those who have been diagnosed with AIDS has brought about new challenges in prevention.

In terms of data collection, the biggest change was the initiation of HIV reporting in September, 1999 (in Pierce County, reporting started in January, 1999). Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were demonstrated, in part, by the AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. The strengths and limitations of these data are described further in the HIV section. Additionally, initiation of HIV surveillance may have been a contributing factor to the increase in AIDS case reporting due to enhanced lab-based reporting and increased attention to surveillance in general.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although seroprevalence rates and case numbers had been decreasing in men who have sex with men (MSM), there is some evidence that these populations are experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color. Optimism about treatment successes may have brought about complacency, but HAART is no substitute for primary prevention. As new recommendations come out to

delay therapy in those who are HIV+, the strategy of “treatment as prevention” may not apply, and the focus needs to return to behavior change.

The year 2000 also brought about renewed focus on prevention in those who are HIV+. The Center for Disease Control’s HIV Prevention Strategic Plan prioritizes people living with HIV as a population to reach in order to reduce the number of new infections. The goal is to increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition. The Institute of Medicine recognized in its report, “No Time to Lose,” that those who are HIV-infected are in “a unique position to stop the spread of HIV.”

Demographic characteristics of Region 5

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Table 1. Characteristics of the AIDSNET Region 5 Population, 1990 and 2000

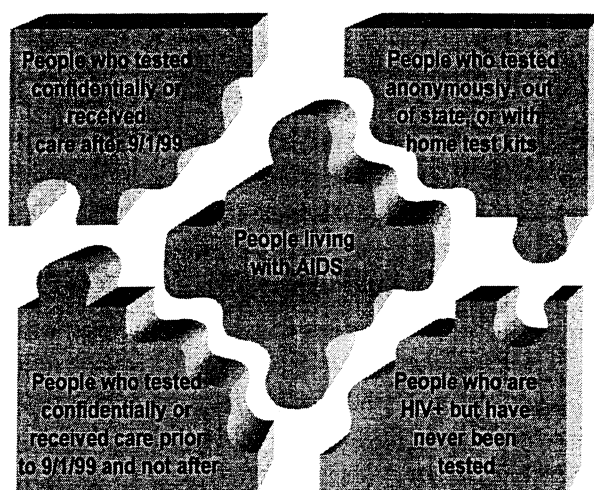
	1990 Census	2000 Census (est.)
Total population, Region 5	775,934	941,967
% of Washington State population	16%	16%
County population (% of Region 5)		
Kitsap	189,731 (24%)	232,521 (25%)
Pierce	586,203 (76%)	709,446 (75%)
Gender		
Female	386,130 (50%)	466,461 (50%)
Male	389,804 (50%)	475,506 (50%)
Race/Ethnicity (Kitsap)		
White	167,982 (89%)	199,498 (86%)
Black	4,978 (3%)	7,441 (3%)
Hispanic	6,167 (3%)	9,037 (4%)
Asian	7,609 (4%)	12,504 (5%)
American Indian/Alaska Native	2,995 (2%)	4,041 (2%)
Race/Ethnicity (Pierce)		
White	488,912 (83%)	567,337 (80%)
Black	41,182 (7%)	53,440 (8%)
Hispanic	20,556 (4%)	30,927 (4%)
Asian	27,825 (5%)	47,627 (7%)
American Indian/Alaska Native	7,728 (1%)	10,115 (1%)
Age		
<=14	183,598 (24%)	218,372 (23%)
15-19	53,855 (7%)	68,749 (7%)
20-29	132,039 (17%)	136,220 (14%)
30-39	134,570 (17%)	142,333 (15%)
40-49	99,768 (13%)	142,838 (15%)
50-59	61,872 (8%)	103,040 (11%)
60+	110,232 (14%)	130,415 (14%)

Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.

HIV data

Preliminary HIV data from Region 5 include HIV cases reported to DOH through 12/31/2000. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 1. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Region 5
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.

- Are not representative of all HIV-infected individuals. As can be seen in **Figure 1**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99 (1/1/99 in Pierce County), when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 (1/1/99 in Pierce County) but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Preliminary data for Region 5 are presented in **Table 2**. HIV cases have been reported from both counties in Region 5. The year of diagnosis (earliest available positive test result) ranges from 1984 to 2000. When compared to recently diagnosed AIDS cases, the HIV cases include a higher proportion of women and, consequently, a higher proportion of cases due to heterosexual transmission. HIV cases also include a higher proportion of cases due to injection drug use. In terms of age, the age of HIV diagnosis is younger than the age of AIDS diagnosis, as expected, so a higher proportion of cases is under the age of 30.

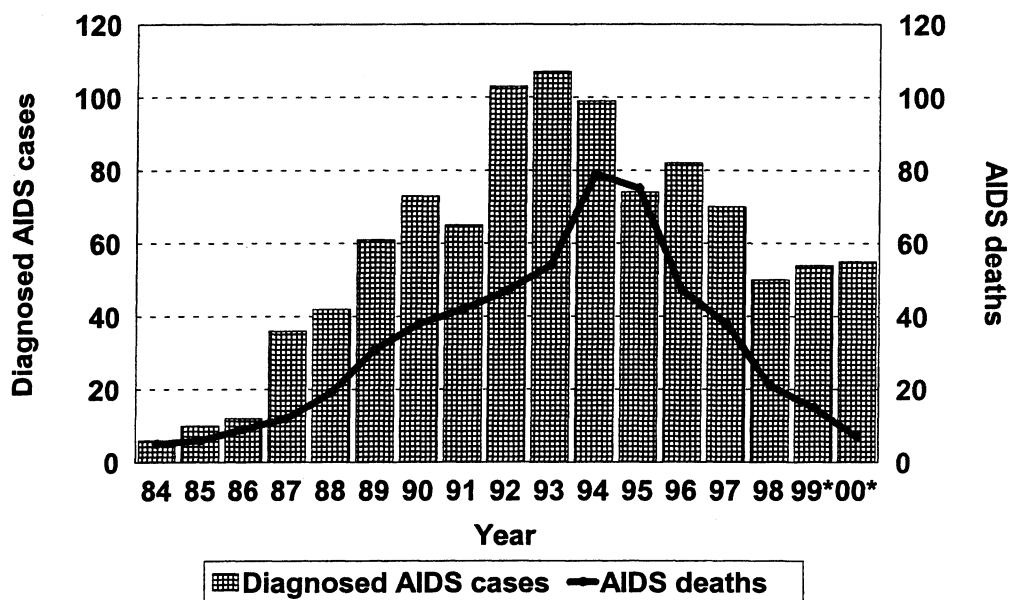
Table 2. HIV infection reported for Region 5 (As of 12/31/2000)
N = 254

County		
	Kitsap	33 (13%)
	Pierce	221 (87%)
Year of diagnosis		
	1984-1989	35 (14%)
	1990-1995	103 (41%)
	96	17 (7%)
	97	22 (9%)
	98	6 (2%)
	99	29 (11%)
	00	42 (17%)
Gender		
	Male	180 (71%)
	Female	74 (29%)
Race/Ethnicity		
	White	173 (68%)
	Black	45 (18%)
	Hispanic	23 (9%)
	Asian/Pacific Islander	5 (2%)
	American Indian/Alaska Native	7 (3%)
	Unknown	1 (<1%)
Mode of exposure		
	MSM	96 (38%)
	IDU	73 (29%)
	MSM/IDU	25 (10%)
	Heterosexual	33 (13%)
	Receipt of blood products	4 (2%)
	Other/Unknown	23 (9%)
Age		
	<13	3 (1%)
	13-19	8 (3%)
	20-29	95 (37%)
	30-39	99 (39%)
	40-49	37 (15%)
	50-59	12 (5%)
	60+	0 (0%)
Disease status		
	Asymptomatic HIV	186 (73%)
	Symptomatic HIV	68 (27%)

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 2** demonstrates the significant declines in AIDS incidence and deaths in Region 5 experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies. When looking at AIDS incidence, it appears that the “stalling” of the decreasing trend being seen at the national level is also being seen in Region 5.

Figure 2. AIDS cases by year of diagnosis and AIDS deaths, AIDSNET Region 5, 1984 – 2000 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The decline in HIV-related mortality has led to an increase in AIDS prevalence. As can be seen in **Figure 3**, the number of people living with AIDS in Region 5 has been increasing, adding to the challenge of providing prevention and care services.

Figure 3. Number of people living with AIDS, AIDSNET Region 5 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete.)

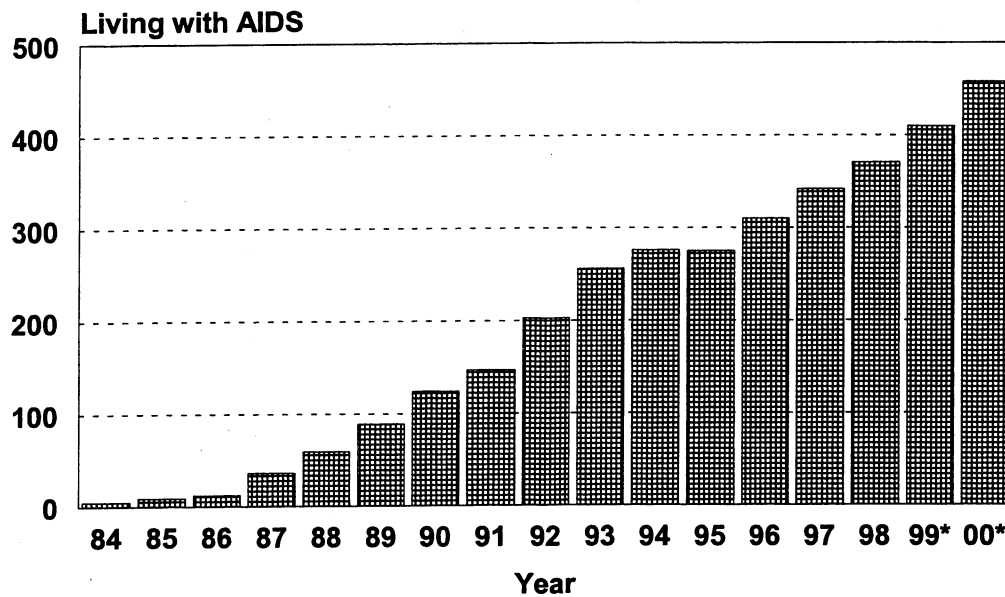


Table 3 describes the changes in the distribution of AIDS cases over time in Region 5. AIDS cases have included an increasing proportion of women, cases due to injection drug use and heterosexual transmission, and people of color, particularly Blacks. While these shifts in the epidemic have been observed in both Kitsap and Pierce Counties, they have been most dramatic in Pierce County.

Table 3. AIDS case trends over three time periods, AIDSNET Region 5

	Year of diagnosis		
	1985-1989 n = 161	1990-1994 n = 447	1995-1999 n = 330
Gender			
Male	94%	87%	75%
Female	6%	13%	25%
Mode of exposure			
MSM	65%	55%	40%
IDU	7%	18%	24%
MSM/IDU	15%	9%	8%
Heterosexual	2%	8%	15%
Receipt of blood products	8%	4%	2%
Other/Unknown	2%	8%	11%
Race/Ethnicity			
White	81%	69%	67%
Black	13%	19%	21%
Hispanic	4%	8%	6%
Asian/Pacific Islander	1%	1%	3%
American Indian/Alaska Native	1%	2%	3%
Unknown	0%	0%	<1%
Age			
<13	2%	1%	1%
13-19	1%	<1%	1%
20-29	32%	25%	16%
30-39	42%	44%	48%
40-49	15%	21%	24%
50-59	7%	6%	8%
60+	2%	3%	3%

HIV/AIDS in behaviorally-defined populations

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of AIDS cases. In Region 5, 53% of those living with AIDS were men exposed through sex with other men (this does not include MSM who also inject drugs). Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Region 5.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories by gender, race/ethnicity, and region of residence for the 453 adults and adolescents living with AIDS who were diagnosed in Region 5.

In looking at these tables, it is important to note that although MSM account for the majority of Region 5 AIDS cases (both in Kitsap County and Pierce County), cases among other HIV exposure categories have occurred and are of particular significance among women and persons of color (Tables 4-6).

Table 4. Adults and adolescents living with AIDS, by exposure category and residence at AIDS diagnosis, AIDSNET Region 5. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 still not considered to be complete).

HIV Exposure Category	Kitsap County	Pierce County	Region 5 Total
Men who have sex with men	38 (54%)	161 (42%)	199 (44%)
Female and heterosexual male injection drug users	8 (11%)	92 (24%)	100 (22%)
MSM who use injection drugs	10 (14%)	28 (7%)	38 (8%)
Heterosexual contacts*	6 (8%)	62 (16%)	68 (15%)
Receipt of blood products	3 (4%)	6 (2%)	9 (2%)
Other/unknown	6 (8%)	33 (9%)	39 (9%)
TOTAL	71	382	453

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 5. Adults and adolescents living with AIDS, by HIV exposure category and sex, AIDSNET Region 5. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)

HIV Exposure Category	Kitsap County		Pierce County	
	Males	Females	Males	Females
Men who have sex with men (MSM)	38 (63%)		161 (56%)	
Female and heterosexual male injection drug users	5 (8%)	3 (27%)	54(19%)	38 (40%)
MSM who use injection drugs	10 (17%)		28 (10%)	
Heterosexual contacts*	1 (2%)	5 (45%)	22 (8%)	40 (42%)
Receipt of blood products	2 (3%)	1 (9%)	4 (1%)	2 (2%)
Other/unknown	4 (7%)	2 (18%)	17 (6%)	16 (17%)
TOTAL	60	11	286	96

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 6A. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, Kitsap County . (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	29 (54%)	6 (60%)	1 (50%)	0 (0%)	2 (67%)
Female and heterosexual male injection drug users	5 (9%)	0 (0%)	1 (50%)	1 (50%)	1 (33%)
MSM who use injection drugs	9 (17%)	1 (10%)	0 (0%)	0 (0%)	0 (0%)
Heterosexual contacts*	3 (6%)	3 (30%)	0 (0%)	0 (0%)	0 (0%)
Receipt of blood products	2 (4%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)
Other/unknown	6 (11)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
TOTAL	54	10	2	2	3

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 6B. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, Pierce County. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	118 (47%)	26 (33%)	9 (27%)	5 (56%)	3 (33%)
Female and heterosexual male injection drug users	58 (23%)	21 (27%)	10 (30%)	0 (0%)	3 (33%)
MSM who use injection drugs	23 (9%)	2 (3%)	2 (6%)	0 (0%)	1 (11%)
Heterosexual contacts*	29 (11%)	20 (26%)	10 (30%)	1 (11%)	2 (22%)
Receipt of blood products	5 (2%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Other/unknown	20 (8%)	8 (10%)	2 (6%)	3 (33%)	0 (0%)
TOTAL	253	78	33	9	9

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Figures 4A and 4B show that the proportion of AIDS cases attributable to MSM has decreased over time in both Kitsap and Pierce Counties (small numbers lead to the more dramatic variations in Kitsap County cases). Increases in proportions of cases due to injection drug use and heterosexual transmission have been more dramatic in Pierce County. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

Figure 4A. Proportion of AIDS cases accounted for by selected HIV exposure groups, Kitsap County, 1989-2000. (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)

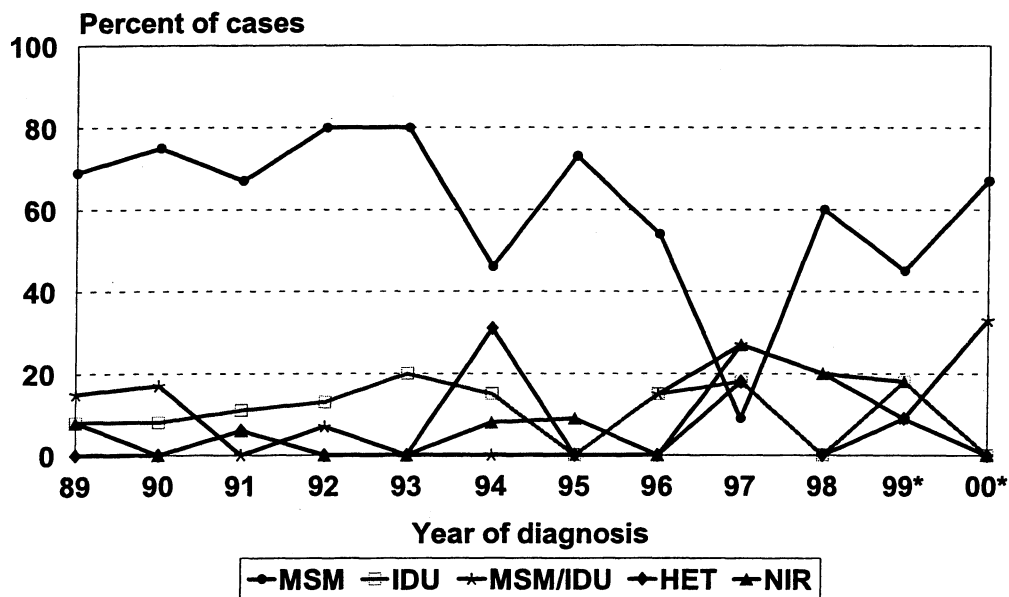
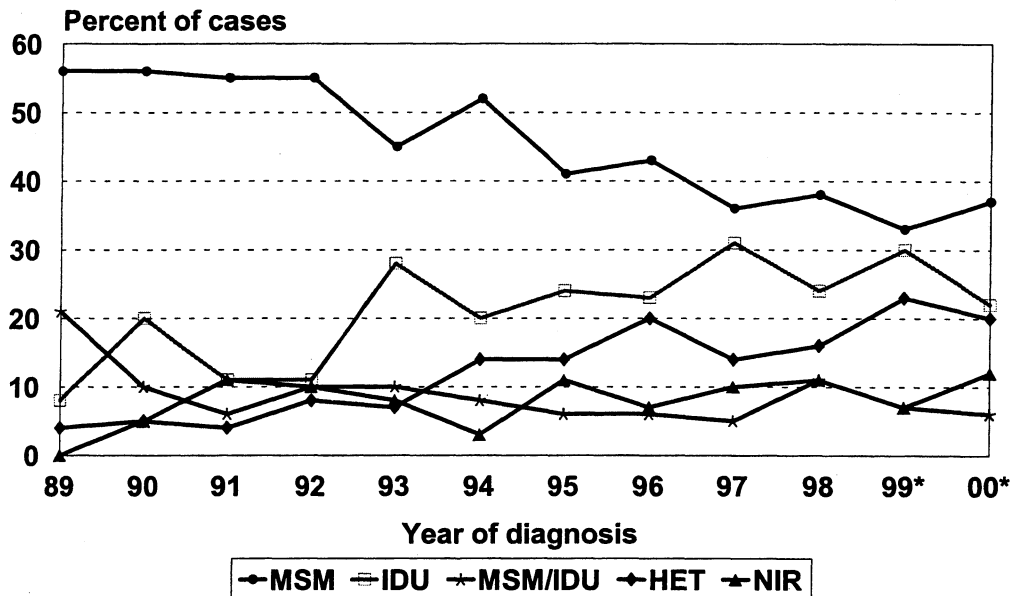


Figure 4B. Proportion of AIDS cases accounted for by selected HIV exposure groups, Pierce County, 1989-2000. (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



HIV/AIDS in demographically-defined populations

A. Adolescents and young adults

AIDS cases and trends

AIDS cases in persons 13-29 years of age reflect HIV transmission which occurred during adolescence or early adulthood. Of the 1,005 AIDS cases diagnosed in Region 5 between 1983 and 2000, 235 (24%) have been among persons 13-29 years of age. Approximately 1% of all cases have been diagnosed among persons 13-19 years of age; 23% have been diagnosed among persons 20-29 years of age. Although the number of AIDS cases among persons 13-19 years of age has been relatively stable, cases among persons 20-29 years of age increased in 1989-1990, decreased in the mid-1990s, and then appear to have leveled out (**Figure 5**). Since the majority of AIDS cases in this age category are attributable to MSM, this trend may in part reflect the statewide trends in white MSM.

All modes of HIV exposure have been reported among adolescents and young adults in Region 5 (**Table 7**). Fifty-one cases in 13-24 year olds have been diagnosed in males (75%), and seventeen cases (25%) have been diagnosed in females. The majority of

cases (41%) have been reported among young men who have had sex with men, with an additional eight cases (12%) due to MSM and injection drug use.

Figure 5. AIDS cases among adolescents and young adults by year of diagnosis, AIDSNET Region 5, 1984-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*).

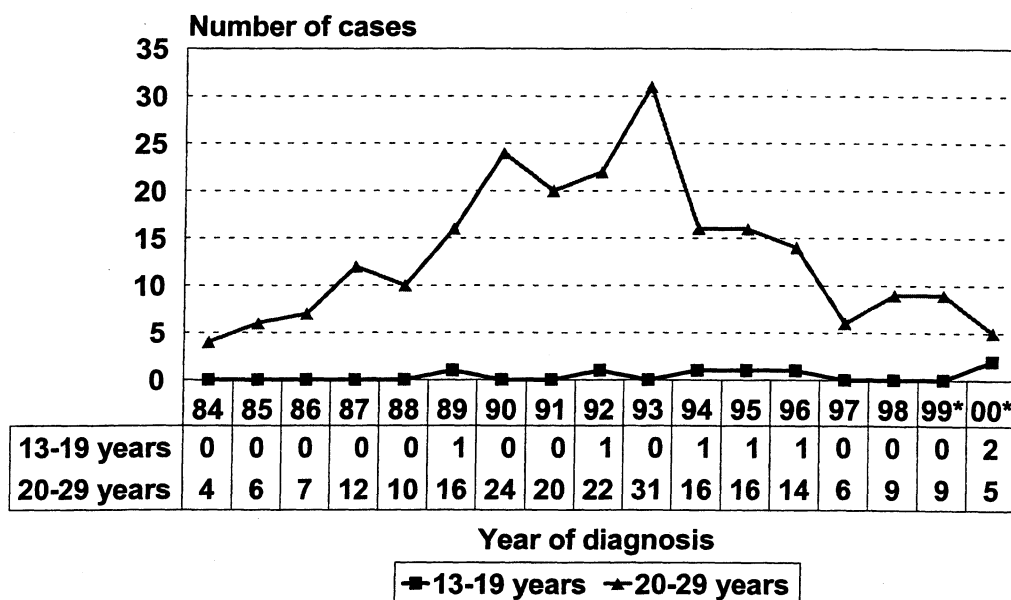


Table 7. Mode of HIV exposure among adolescents and young adults (13-24 years), AIDSNET Region 5, 1983-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

Exposure category	Number (%)
Men who have sex with men (MSM)	28 (41%)
Female and heterosexual male injection drug user	10 (15%)
MSM who used injection drugs	8 (12%)
Heterosexual contact*	7 (10%)
Receipt of blood products	8 (12%)
Not reported/unknown	7 (10%)
TOTAL	68

*Heterosexual contact with a person with HIV or known to be at risk for HIV.

B. People of color

Although transmission of HIV results from certain high risk behaviors and is not the result of one's race or ethnicity, racial and ethnic minorities have been disproportionately affected by the HIV epidemic and, therefore, will be considered separately.

AIDS cases and trends

A total of 303 AIDS cases have been diagnosed between 1983 and 2000 among people of color who were residents of Region 5 at the time of diagnosis. These cases account for 30% of the AIDS cases from this region. The number of cases among people of color increased through the mid-1990s, then declined, and appears to have stabilized in last few years (**Figures 6A, 6B and 6C**). The number of cases in Kitsap County is small, so numbers are less stable. Of the 303 cases diagnosed in Region 5 among people of color, 43% have been diagnosed since 1995.

Figure 6A. AIDS cases among people of color, AIDSNET Region 5, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*.)

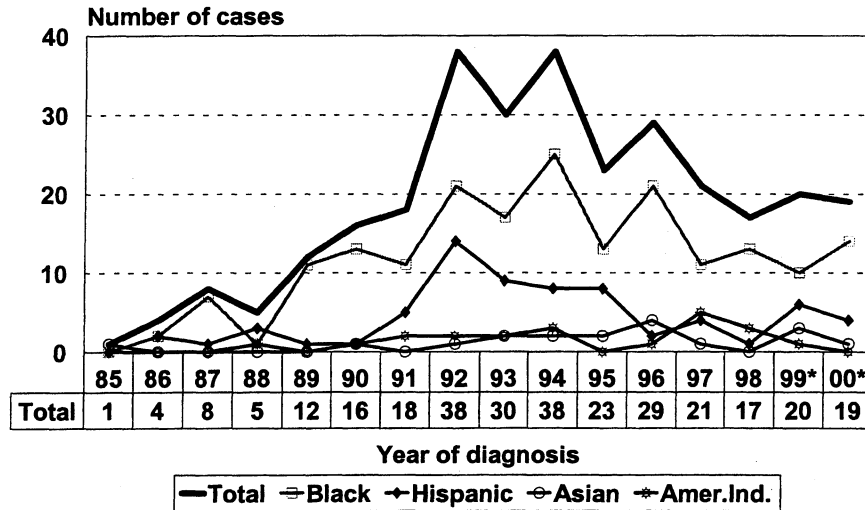


Figure 6B. AIDS cases among people of color, Kitsap County, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)*

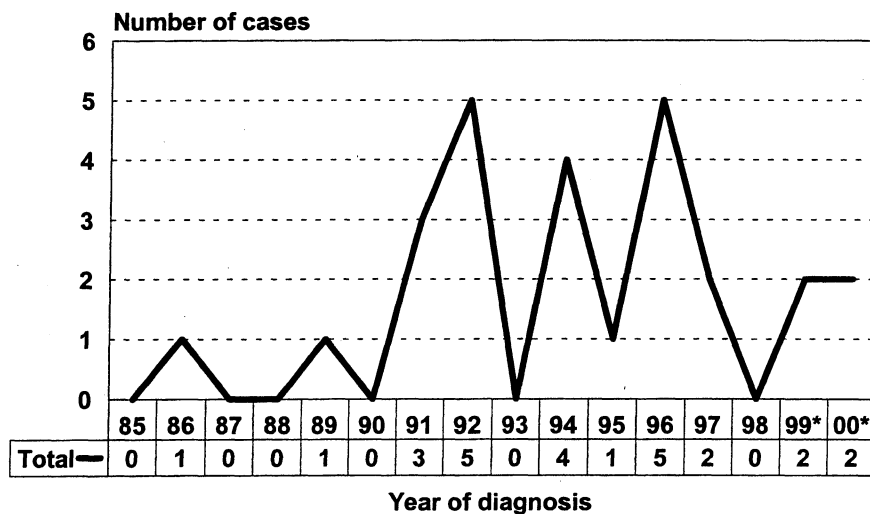
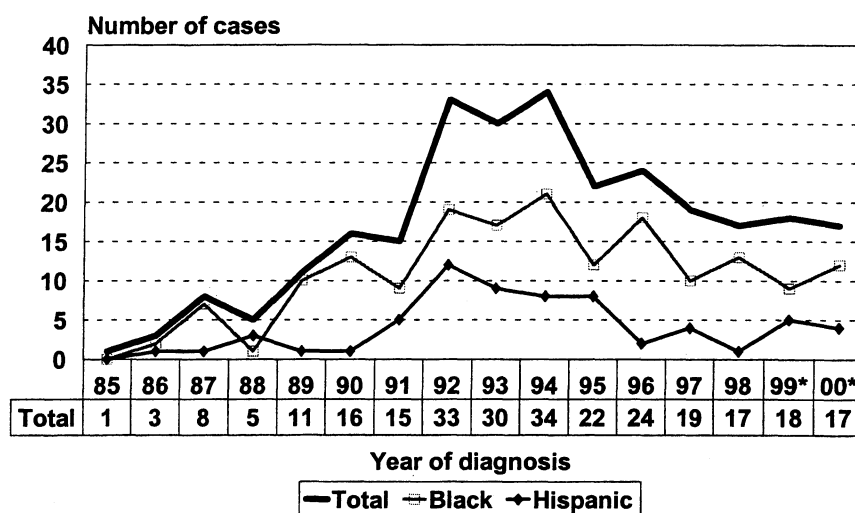


Figure 6C. AIDS cases among people of color, Pierce County, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)*



C. Women

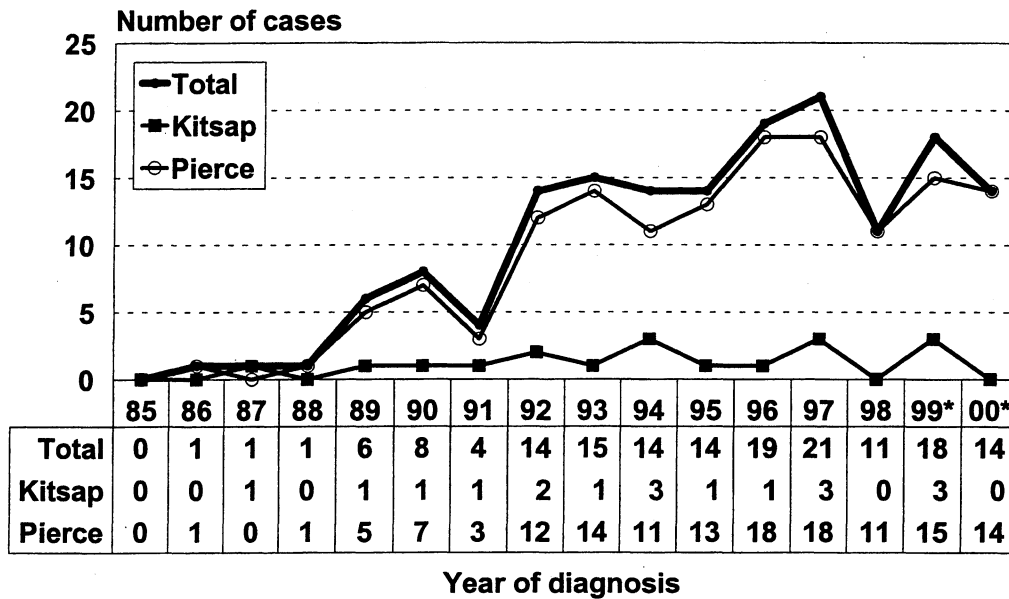
Women, as a general group, are not at increased risk for HIV. However, specific prevention programs can be targeted toward women (e.g., AZT during pregnancy); furthermore, the proportion of cases among women seems to be increasing as a result of increasing cases among injection drug users and their heterosexual partners. As a result, data on women are presented as a separate section.

AIDS cases and trends

From 1983-2000, 161 cases of AIDS were reported among women (≥ 13 years of age) who were residents of Region 5 at the time of diagnosis. The cases among women accounted for 16% of all Region 5 AIDS cases.

The number of AIDS cases among women in Region 5 increased through 1997 and now appears to be leveling out (**Figure 7**). Women have been making up an increasing proportion of AIDS cases in Region 5 (**Table 3**).

Figure 7. AIDS cases among women by year of diagnosis, AIDSNET Region 5, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).



Of the 161 cumulative cases among women, 83 (51%) were white, 52 (32%) were Black, 19 (12%) were Hispanic, five (3%) were Asian/Pacific Islander and four (2%) were American Indian/Alaska Native.

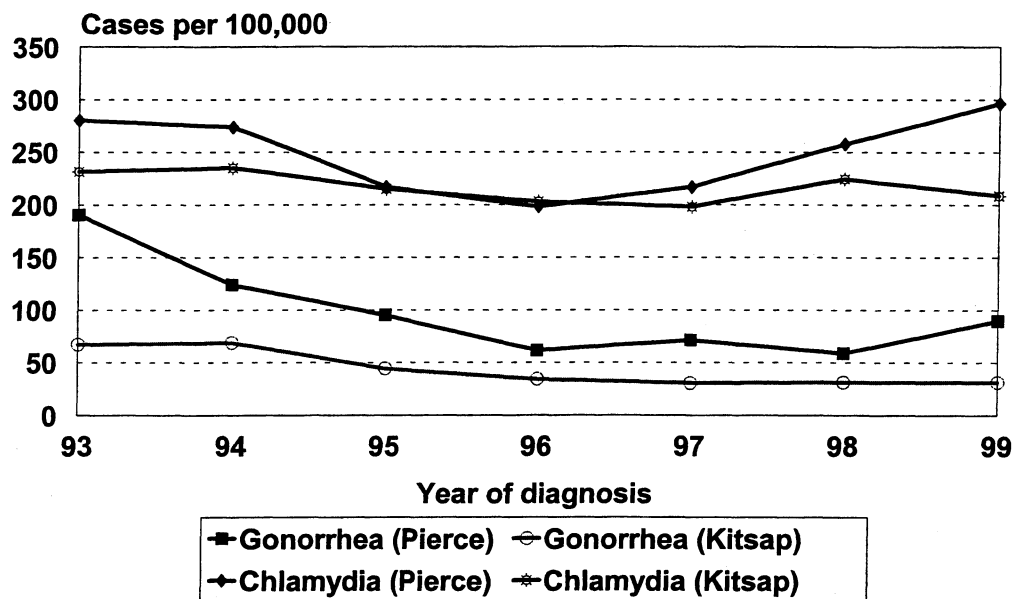
The majority of women living with AIDS in Region 5 (45 cases or 42%) acquired HIV from heterosexual contact with a person with HIV or known to be at risk for HIV; 41 cases (38%) occurred among female injection drug users. Of the 45 cases resulting from heterosexual contact, 21(47%) were due to heterosexual contact with someone with HIV/AIDS (exposure risk unknown), 17 (38%) were due to heterosexual contact with an injection drug user, and seven (16%) were due to heterosexual contact with a bisexual male. Although numbers are small, injection drug use is more often the mode of HIV exposure for women who are white when compared to women of color (47% vs. 28%, respectively, for those women living with AIDS), and heterosexual transmission is more often the mode of HIV exposure for women of color when compared to women who are white (50% vs. 35%, respectively, for those women living with AIDS).

Surrogate indicators

In addition to HIV and AIDS-related data, it is important to consider other sources of data that may indicate risk behavior. **Figure 8** and **Tables 2-4 in the Appendix**

describe some of these surrogate indicators. Chlamydia and gonorrhea case rates have increased in Pierce County, while rates have remained relatively stable in Kitsap County. STD case rates are higher in people of color and people who are younger. Teen pregnancy rates have been stable. Hepatitis B cases have been declining over time and are a less useful indicator of risk behavior due, in part, to the availability of a vaccine. In Pierce County, approximately 1,800 injection drug users were tested for HIV as a result of a hepatitis screening program in 2000; in this population, seropositivity for HIV was 1.1%. Chronic hepatitis C became reportable in December 2000, and data related to this indicator will provide information about certain at-risk populations in the future.

Figure 8. Chlamydia and gonorrhea case rates for Region 5, 1993 – 1999.



APPENDIX

Table 1. AIDS cases by county of residence at diagnosis, AIDSNET Region 5, 1983-2000 (Cases reported as of December 31, 2000.)*

COUNTY	YEAR																TOTAL	LIVING**
	<=85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00		
Kitsap	6	2	7	13	13	12	18	15	10	13	11	13	11	5	11	6	166	71
Pierce	16	10	29	29	48	61	47	88	97	86	63	69	59	45	43	49	839	386
TOTAL	22	12	36	42	61	73	65	103	107	99	74	82	70	50	54	55	1005	457

*Due to delays in reporting, case counts for 1999 and 2000 are still not considered to be complete.

**Based on known deaths as of September 30, 2000.

Table 2. Cases of gonorrhea by county of residence at diagnosis, AIDSNET Region 5, 1982-1999.

COUNTY	YEAR																		
	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	
Kitsap	241	209	151	181	189	107	90	88	107	100	135	141	147	98	77	70	72	72	
Pierce	1806	1452	1467	1766	1651	1365	1316	1376	985	783	1021	1220	805	631	411	479	405	628	
TOTAL	2047	1661	1618	1947	1840	1472	1406	1464	1092	883	1156	1361	952	729	488	549	477	700	

Table 3. Cases of hepatitis B by county of residence at time of diagnosis, AIDSNET Region 5, 1988-1999.

COUNTY	YEAR												
	88	89	90	91	92	93	94	95	96	97	98	99	
Kitsap	10	26	17	6	13	2	14	11	3	3	3	4	
Pierce	158	182	71	43	45	33	35	26	17	15	11	7	
TOTAL	168	208	88	49	58	35	49	37	20	18	14	11	

Table 4. Pregnancies (including abortions and births) among women 15-17 years of age by county of residence, AIDSNET Region 5, 1985-1998.

COUNTY	YEAR													
	85	86	87	88	89	90	91	92	93	94	95	96	97	98
Kitsap	171	208	189	201	204	205	203	228	212	208	189	185	192	174
Pierce	766	775	783	704	723	709	760	775	785	736	722	777	747	711
TOTAL	937	983	972	905	927	914	963	1003	997	944	911	962	939	885

AIDSNET REGION 6

HIV/AIDS EPIDEMIOLOGIC PROFILE

Update 2001

**Clallam, Clark, Cowlitz, Grays Harbor,
Jefferson, Lewis, Mason, Pacific, Skamania,
Thurston and Wahkiakum Counties**



**Assessment Unit
Infectious Disease and Reproductive Health**

HIV/AIDS Epidemiologic Profile AIDSNET Region 6 – Update 2001

Purpose

The purpose of this report is to give people involved in HIV prevention community planning in Region 6 updated information related to HIV/AIDS and other related surrogate markers. Although it contains much of the data necessary for the decision-making process, it is not all-inclusive, and does not contain information from all possible data sources, definitions of terms, and information about data sources. It is recommended that readers consult the **1998 AIDSNET Region 6 HIV/AIDS Epidemiologic Profile** for further information.

What's new?

Nationally, the rates of decline in AIDS incidence and deaths resulting from the impact of highly active antiretroviral therapy slowed during the latter part of 1998 and 1999. This "stalling" of the trends appears to be taking place at the local level as well. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. At the same time, AIDS prevalence has been increasing, although the rate of increase has slowed. Prolonged health and survival of those who have been diagnosed with AIDS has brought about new challenges in prevention.

In terms of data collection, the biggest change was the initiation of HIV reporting in September, 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were demonstrated, in part, by the AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. The strengths and limitations of these data are described further in the HIV section. Additionally, initiation of HIV surveillance may have been another contributing factor to the increase in AIDS case reporting due to enhanced lab-based reporting and increased attention to surveillance in general.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although seroprevalence rates and case numbers had been decreasing in men who have sex with men (MSM), there is some evidence that these populations are experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color. Optimism about treatment successes may have brought about complacency, but HAART is no substitute for primary prevention. As new recommendations come out to

delay therapy in those who are HIV+, the strategy of “treatment as prevention” may not apply, and the focus needs to return to behavior change.

The year 2000 also brought about renewed focus on prevention in those who are HIV+. The Center for Disease Control’s HIV Prevention Strategic Plan prioritizes people living with HIV as a population to reach in order to reduce the number of new infections. The goal is to increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition. The Institute of Medicine recognized in its report, “No Time to Lose,” that those who are HIV-infected are in “a unique position to stop the spread of HIV.”

Demographic characteristics of Region 6

Table 1 presents some of the demographic characteristics of Region 6, including both the 1990 census figures and the 2000 estimates (2000 census data are not yet available). Comparison of the distribution of the general population and the distribution of those with HIV/AIDS allows for identification of populations that are overrepresented in the epidemic.

Table 1. Characteristics of the AIDSNET Region 6 Population, 1990 and 2000

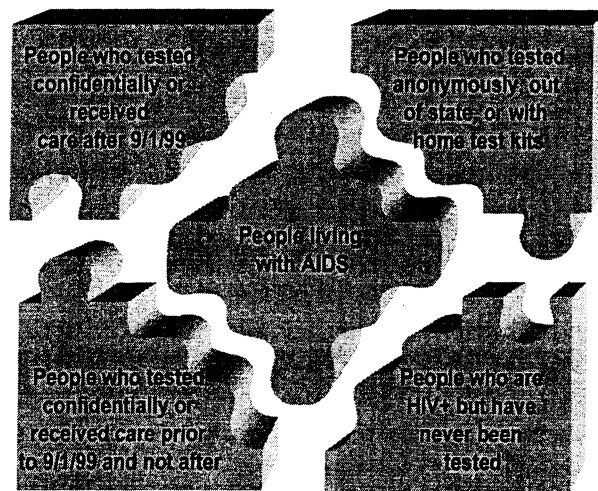
	1990 Census	2000 Census (est.)
Total population, Region 6	750,392	956,605
% of Washington State population	15%	16%
County population (% of Region 6)		
Clallam	56,464 (7.5%)	67,551 (7.1%)
Clark	238,053 (31.7%)	342,610 (35.8%)
Cowlitz	82,119 (10.9%)	95,306 (10.0%)
Grays Harbor	64,175 (8.5%)	66,912 (7.0%)
Jefferson	20,146 (2.7%)	26,420 (2.8%)
Lewis	59,358 (7.9%)	68,858 (7.2%)
Mason	38,341 (5.1%)	48,529 (5.1%)
Pacific	18,882 (2.5%)	21,376 (2.2%)
Skamania	8,289 (1.1%)	9,926 (1.0%)
Thurston	161,238 (21.5%)	205,252 (21.5%)
Wahkiakum	3,327 (<1%)	3,865 (<1%)
Gender		
Female	379,699 (51%)	483,677 (51%)
Male	370,693 (49%)	472,928 (49%)
Race/Ethnicity		
White	696,152 (92.8%)	862,604 (90.2%)
Black	6,957 (1.0%)	12,429 (1.3%)
Hispanic	14,205 (1.9%)	19,280 (2.0%)
Asian	15,163 (2.0%)	30,172 (3.2%)
American Indian/Alaska Native	17,897 (2.4%)	32,120 (3.4%)
Age		
<=14	172,114 (22.9%)	211,901 (22.2%)
15-19	51,788 (6.9%)	70,302 (7.3%)
20-29	96,170 (12.8%)	109,300 (11.4%)
30-39	125,203 (16.7%)	133,437 (13.9%)
40-49	103,576 (13.8%)	153,254 (16.0%)
50-59	66,174 (8.8%)	117,021 (12.2%)
60+	135,367 (18.0%)	161,390 (16.9%)

Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.

HIV data

Preliminary HIV data from Region 6 include HIV cases reported to DOH through 12/31/2000. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 1. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Region 6
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.

- Are not representative of all HIV-infected individuals. As can be seen in **Figure 1**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Preliminary data for Region 6 are presented in **Table 2**. HIV cases have been reported from most counties in Region 6 (with the exception of Pacific and Skamania Counties). The year of diagnosis (earliest available positive test result) ranges from 1984 to 2000. When compared to recently diagnosed AIDS cases, the HIV cases include a higher proportion of women and, consequently, a higher proportion of cases due to heterosexual transmission. HIV cases also include a higher proportion of cases with no identified risk, primarily because these cases are earlier in the course of infection and may not know their risk factors or may not have shared the information with a provider. Additionally, many HIV cases are identified through laboratory reporting, so risk is more difficult to ascertain. In terms of age, the age of HIV diagnosis is younger than the age of AIDS diagnosis, as expected, so a higher proportion of cases is under the age of 30.

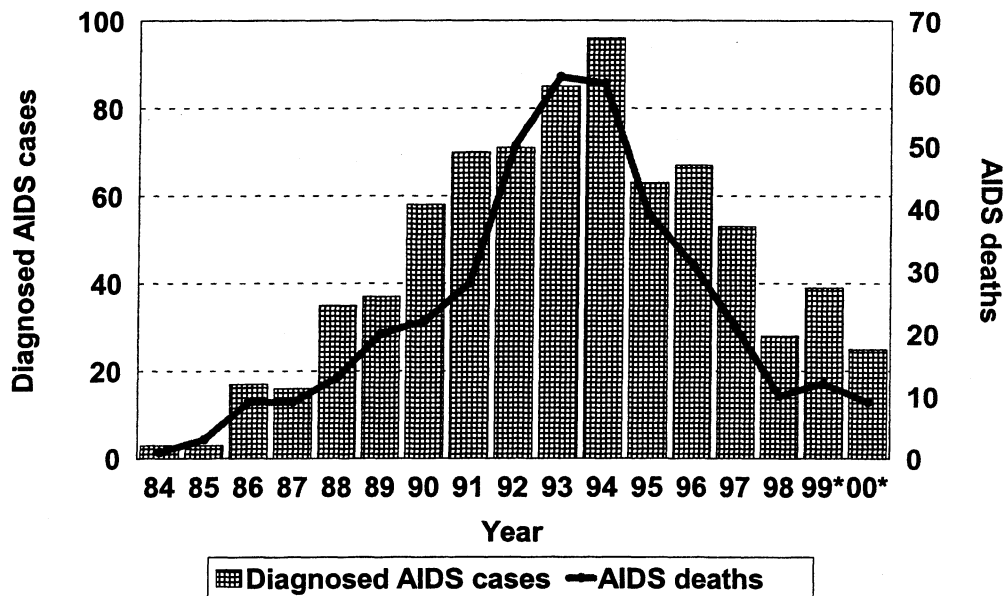
Table 2. HIV infection reported for Region 6 (As of 12/31/2000)
N = 151

County		
	Clallam	11 (7%)
	Clark	62 (41%)
	Cowlitz	10 (7%)
	Grays Harbor	6 (4%)
	Jefferson	5 (3%)
	Lewis	6 (4%)
	Mason	13 (9%)
	Thurston	37 (25%)
	Wahkiakum	1 (1%)
Year of diagnosis		
	1984-1989	20 (13%)
	1990-1995	60 (40%)
	96	12 (8%)
	97	14 (9%)
	98	9 (6%)
	99	21 (14%)
	00	15 (10%)
Gender		
	Male	116 (77%)
	Female	35 (23%)
Race/Ethnicity		
	White	127 (84%)
	Black	9 (6%)
	Hispanic	5 (3%)
	Asian/Pacific Islander	3 (2%)
	American Indian/Alaska Native	1 (1%)
	Unknown	6 (4%)
Mode of exposure		
	MSM	63 (42%)
	IDU	24 (16%)
	MSM/IDU	12 (8%)
	Heterosexual	25 (17%)
	Receipt of blood products	2 (1%)
	Other/Unknown	25 (17%)
Age		
	<13	3 (2%)
	13-19	3 (2%)
	20-29	49 (32%)
	30-39	56 (37%)
	40-49	33 (22%)
	50-59	5 (3%)
	60+	2 (1%)
Disease status		
	Asymptomatic HIV	114 (76%)
	Symptomatic HIV	37 (24%)

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 2** demonstrates the significant declines in AIDS incidence and deaths in Region 6 experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies. It also shows the “stalling” of these trends starting in 1998.

Figure 2. AIDS cases by year of diagnosis and AIDS deaths, AIDSNET Region 6, 1984 – 2000 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete*.)



The decline in HIV-related mortality has led to an increase in AIDS prevalence. As can be seen in **Figure 3**, the number of people living with AIDS in Region 6 has been increasing, adding to the challenge of providing prevention and care services.

Figure 3. Number of people living with AIDS, AIDSNET Region 6 (Note: Cases reported as of December 31, 2000; reporting for 1999 and 2000 is still not considered to be complete.)

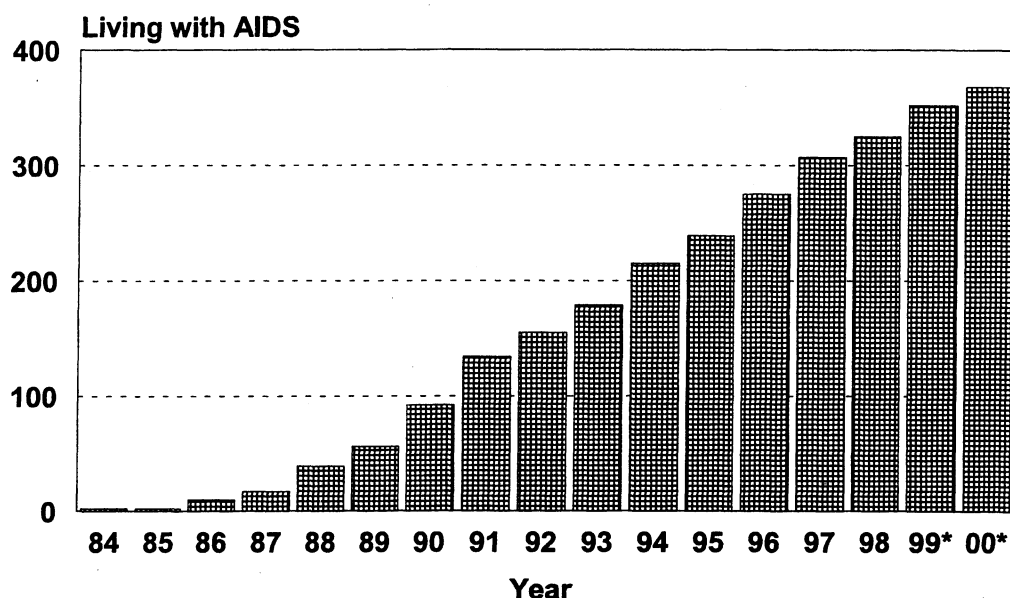


Table 3 describes the changes in the distribution of AIDS cases over time in Region 6. AIDS cases have included an increasing proportion of women, cases due to injection drug use and heterosexual transmission, and people of color, particularly Blacks and Hispanics. Additionally, the proportion of those diagnosed with AIDS who are over 40 years of age has been getting larger. This increase may be due, in part, to the ability of the new therapies to keep people from reaching an AIDS diagnosis until a later point in time.

Table 3. AIDS case trends over three time periods, AIDSNET Region 6

	Year of diagnosis		
	1985-1989 n = 108	1990-1994 n = 380	1995-1999 n = 250
Gender			
Male	94%	89%	85%
Female	6%	11%	15%
Mode of exposure			
MSM	60%	64%	50%
IDU	10%	13%	21%
MSM/IDU	13%	8%	7%
Heterosexual	4%	9%	12%
Receipt of blood products	12%	3%	2%
Other/Unknown	1%	3%	8%
Race/Ethnicity			
White	95%	91%	81%
Black	1%	3%	7%
Hispanic	3%	3%	9%
Asian/Pacific Islander	1%	1%	1%
American Indian/Alaska Native	0%	3%	1%
Unknown	0%	0%	1%
Age			
<13	0%	<1%	0%
13-19	1%	1%	0%
20-29	15%	20%	16%
30-39	33%	46%	42%
40-49	29%	24%	31%
50-59	14%	5%	6%
60+	8%	4%	5%

HIV/AIDS in behaviorally-defined populations

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of AIDS cases. In Region 6, 52% of those living with AIDS were men exposed through sex with other men. Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Region 6.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories by gender, race/ethnicity, and region of residence for the 367 adults and adolescents living with AIDS who were diagnosed in Region 6.

In looking at these tables, it is important to note that although MSM account for the majority of Region 6 AIDS cases (in all three subregions), cases among other HIV exposure categories have occurred and are of particular significance among women and persons of color (Tables 4-6).

Table 4. Adults and adolescents living with AIDS, by HIV exposure category and sex, AIDSNET Region 6. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Region 6 Total
Men who have sex with men (MSM)	190 (60%)		190 (52%)
Female and heterosexual male injection drug users	58 (18%)	18 (35%)	76 (21%)
MSM who use injection drugs	28 (9%)		28 (8%)
Heterosexual contacts*	13 (4%)	23 (45%)	36 (10%)
Receipt of blood products	9 (3%)	1 (2%)	10 (3%)
Other/unknown	18 (6%)	9 (18%)	27 (7%)
TOTAL	316	51	367

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 5. Adults and adolescents living with AIDS, by exposure category and race/ethnicity, AIDSNET Region 6. (Cases reported as December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	168 (55%)	6 (22%)	9 (36%)	4 (80%)	2 (40%)
Female and heterosexual male injection drug users	62 (20%)	6 (22%)	5 (20%)	1 (20%)	2 (40%)
MSM who use injection drugs	25 (8%)	3 (11%)	0 (0%)	0 (0%)	0 (0%)
Heterosexual contacts*	24 (8%)	6 (22%)	5 (20%)	0 (0%)	1 (20%)
Receipt of blood products	9 (3%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)
Other/unknown	16 (5%)	6 (22%)	5 (20%)	0 (0%)	0 (0%)
TOTAL	304	27	25	5	5

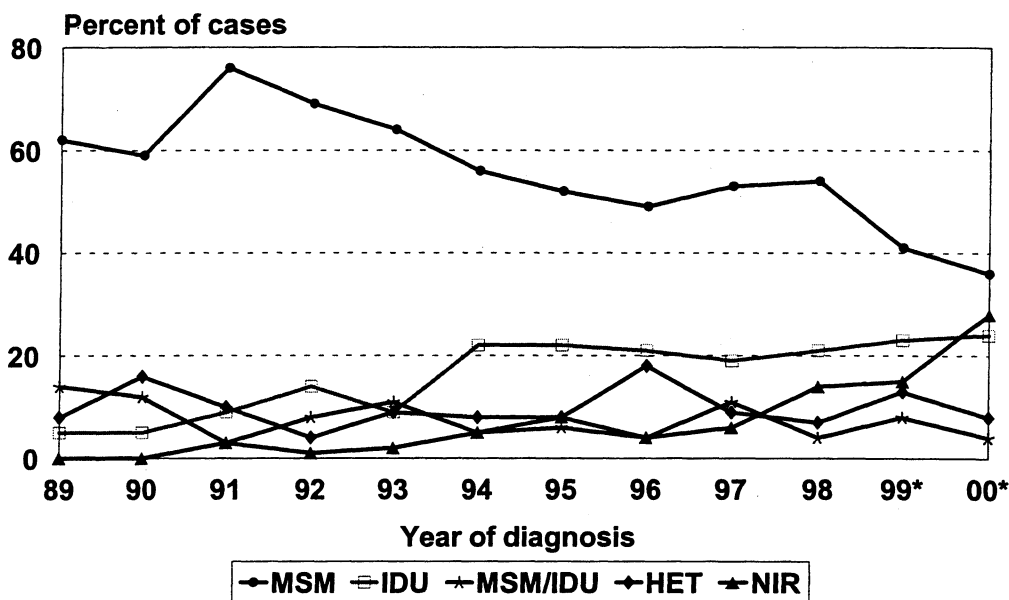
*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes one person of unknown race/ethnicity.

Table 6. Adults and adolescents living with AIDS, by exposure category and residence at AIDS diagnosis, AIDSNET Region 6. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 still not considered to be complete).

HIV Exposure Category	Lower Region 6	Mid- Region 6	Upper Region 6	Region 6 Total
Men who have sex with men	99 (54%)	70 (47%)	21 (60%)	190 (52%)
Female and heterosexual male injection drug users	27 (15%)	43 (29%)	6 (17%)	76 (21%)
MSM who use injection drugs	14 (8%)	11 (7%)	3 (9%)	28 (8%)
Heterosexual contacts*	22 (12%)	10 (7%)	4 (11%)	36 (10%)
Receipt of blood products	4 (2%)	5 (3%)	1 (3%)	10 (3%)
Other/unknown	17 (9%)	10 (7%)	0 (0%)	27 (7%)
TOTAL	183	149	35	367

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Figure 4. Proportion of AIDS cases accounted for by selected HIV exposure groups, AIDSNET Region 6, 1989-2000. (Note: Cases reported as of December 31, 1999; reporting for 1999 and 2000 is still not considered to be complete*.)



The proportion of AIDS cases attributable to MSM has been decreasing in Region 6 as it has in other areas of the state. **Figure 4** shows that the proportion of AIDS cases in this population has been decreasing gradually since 1991 (as a result of increases in cases in other transmission risk categories). The proportion of cases due to injection drug use has been increasing, and there has been a small but steady increase in the proportion of cases due to heterosexual transmission. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

HIV/AIDS in demographically-defined populations

A. Adolescents and young adults

AIDS cases and trends

AIDS cases in persons 13-29 years of age reflect HIV transmission which occurred during adolescence or early adulthood. Of the 766 AIDS cases diagnosed in Region 6 between 1982 and 2000, 142 (19%) have been among persons 13-29 years of age. Only about 1% of all cases have been diagnosed among persons 13-19 years of age; 18% have been diagnosed among persons 20-29 years of age. Although the number of AIDS cases

among persons 13-19 years of age has been relatively stable, cases among persons 20-29 years of age increased in 1989-1990, decreased in the mid-1990s, and then appear to have leveled out (**Figure 5**). Since the majority of AIDS cases in this age category are attributable to MSM, this trend may in part reflect the statewide trends in white MSM.

All modes of HIV exposure have been reported among adolescents and young adults in Region 6 (**Table 7**). Thirty cases in 13-24 year olds have been diagnosed in males (77%), and nine cases (23%) have been diagnosed in females. The majority of cases (51%) have been reported among young men who have had sex with men.

Figure 5. AIDS cases among adolescents and young adults by year of diagnosis, AIDSNET Region 6, 1984-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*).

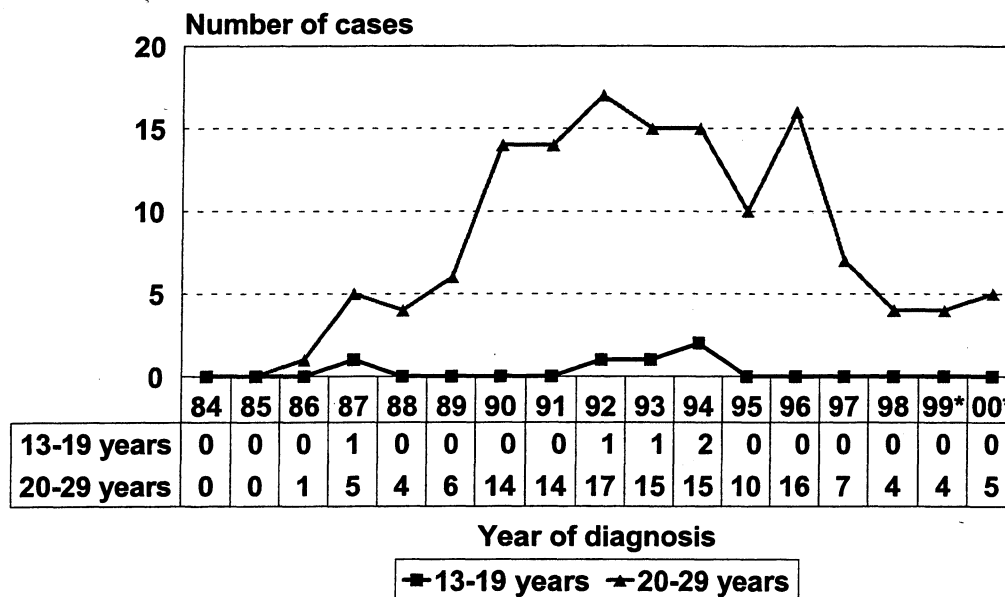


Table 7. Mode of HIV exposure among adolescents and young adults (13-24 years) by gender, AIDSNET Region 6, 1982-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).

Exposure category	Number (%)
Men who have sex with men (MSM)	20 (51%)
Female and heterosexual male injection drug user	4 (10%)
MSM who used injection drugs	1 (3%)
Heterosexual contact*	6 (15%)
Receipt of blood products	4 (10%)
Not reported/unknown	4 (10%)
TOTAL	39

*Heterosexual contact with a person with HIV or known to be at risk for HIV.

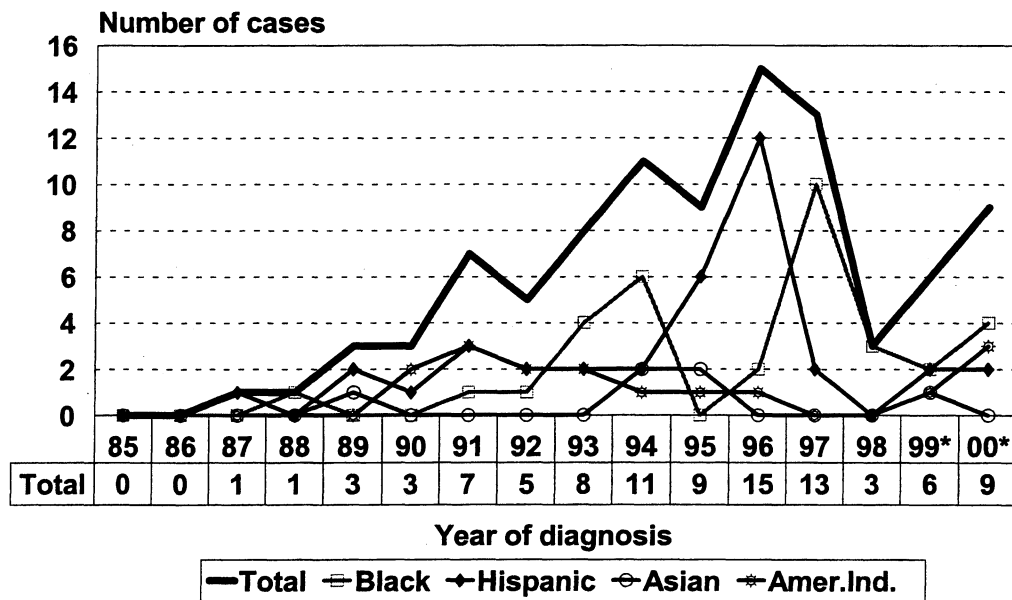
B. People of color

Although transmission of HIV results from certain high risk behaviors and is not the result of one's race or ethnicity, racial and ethnic minorities have been disproportionately affected by the HIV epidemic and, therefore, will be considered separately.

AIDS cases and trends

A total of 93 AIDS cases have been diagnosed between 1982 and 2000 among people of color who were residents of Region 6 at the time of diagnosis. These cases account for 12% of the AIDS cases from this region. The number of cases among people of color increased through 1996, then declined, and appears to have increased in the last few years (**Figure 6**). Since the numbers of cases are small, trends must be interpreted with caution. Of the 93 cases diagnosed in Region 6 among people of color, almost 60% (55) have been diagnosed since 1995.

Figure 6. AIDS cases among people of color, AIDSNET Region 6, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete*.)



C. Women

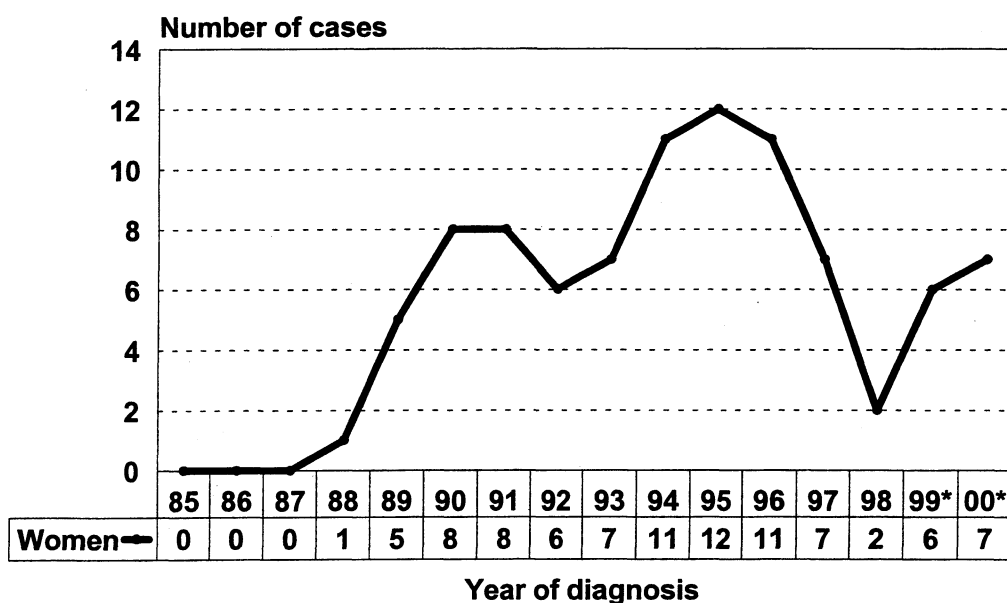
Women, as a general group, are not at increased risk for HIV. However, specific prevention programs can be targeted toward women (e.g., AZT during pregnancy); furthermore, the proportion of cases among women seems to be increasing as a result of increasing cases among injection drug users and their heterosexual partners. As a result, data on women are presented as a separate section.

AIDS cases and trends

From 1982-2000, 91 cases of AIDS were reported among women (≥ 13 years of age) who were residents of Region 6 at the time of diagnosis. The cases among women accounted for 12% of all Region 6 AIDS cases.

The number of AIDS cases among women in Region 6 declined through 1998 and now appears to be leveling out (trends must be interpreted with caution due to small numbers) (**Figure 7**). Women have been making up an increasing proportion of AIDS cases in Region 6 (**Table 3**).

Figure 7. AIDS cases among women by year of diagnosis, AIDSNET Region 6, 1985-2000. (Cases reported as of December 31, 2000; case reporting for 1999 and 2000 is still not considered to be complete).



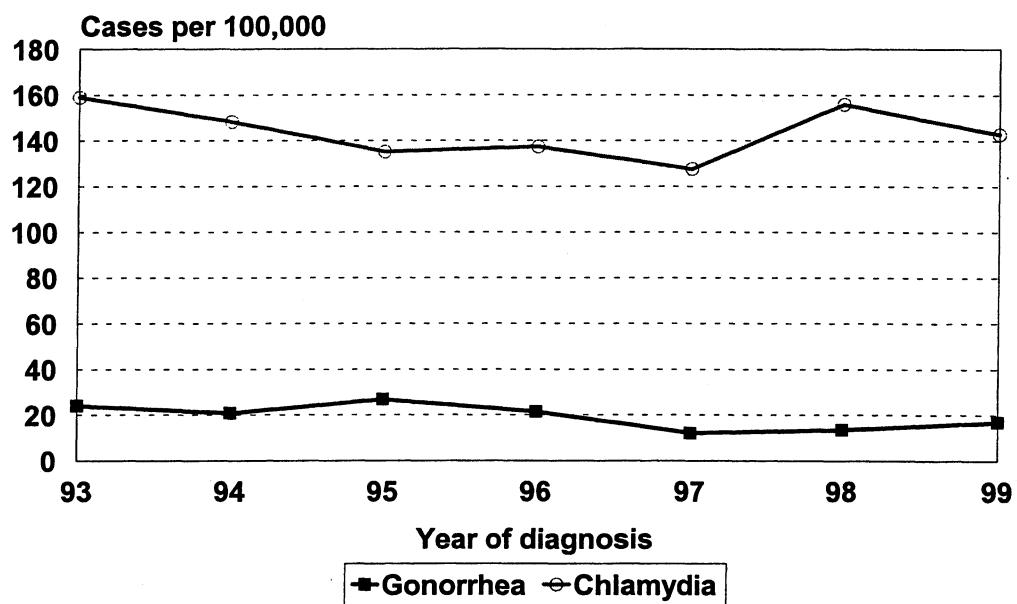
Of the 91 cases among women, 75 (82%) were white, eight (9%) were Black, two (2%) were Hispanic, one (1%) was Asian/Pacific Islander and five (5%) were American Indian/Alaska Native.

The majority of women living with AIDS in Region 6 (23 cases or 45%) acquired HIV from heterosexual contact with a person with HIV or known to be at risk for HIV (**Table 4**); eighteen cases occurred among female injection drug users. Of the 23 cases resulting from heterosexual contact, twelve (52%) were due to heterosexual contact with an injection drug user, 8 (35%) were due to heterosexual contact with someone with HIV/AIDS (exposure risk unknown), two (9%) were due to heterosexual contact with a bisexual male, and one (4%) was due to heterosexual contact with a hemophiliac. The number of cases among women was too small to identify any differences in HIV exposure by race/ethnicity.

Surrogate indicators

In addition to HIV and AIDS-related data, it is important to consider other sources of data that may indicate risk behavior. **Figure 8 and Tables 2-4 in the Appendix** describe some of these surrogate indicators, none of which has dramatically changed in the last few years. STD case rates have been relatively stable over time, with higher rates in people of color and people who are younger. Teen pregnancy rates have also been stable. Hepatitis B cases have been declining over time and are a less useful indicator of risk behavior due, in part, to the availability of a vaccine. Chronic hepatitis C became reportable in December 2000, and data related to this indicator will provide information about certain at-risk populations in the future.

Figure 8. Chlamydia and gonorrhea case rates for Region 6, 1993 – 1999.



APPENDIX

Table 1. AIDS cases by county of residence at diagnosis, AIDSNET Region 6, 1984-2000 (Cases reported as of December 31, 2000).*

COUNTY	YEAR														TOTAL	LIVING**
	<=87	88	89	90	91	92	93	94	95	96	97	98	99*	00*		
Cllallam	1	4	2	5	5	2	3	3	3	5	3	3	5	1	45	23
Clark	20	13	12	26	27	41	34	41	21	31	22	10	16	11	325	144
Cowlitz	4	3	4	10	6	8	7	8	9	8	6	2	2	3	80	36
Grays Harbor	3	2	4	3	2	3	5	4	6	1	2	1	4	1	41	20
Jefferson	3	1	3	1	1	0	2	5	0	2	1	2	1	1	23	12
Lewis	1	5	1	3	4	1	9	4	3	0	1	1	3	0	36	13
Mason	1	2	3	1	2	4	6	10	9	5	9	3	1	4	60	46
Pacific	1	1	1	0	4	1	0	1	2	0	0	0	1	0	12	4
Skamania	2	0	1	1	0	1	1	1	0	0	0	0	0	0	7	2
Thurston	3	4	6	8	19	10	18	19	10	15	9	5	6	3	135	66
Wahkiakum	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	2
TOTAL	39	35	37	58	70	71	85	96	63	67	53	28	39	25	766	368

* Due to delays in reporting, case counts for 1999 and 2000 are still not considered complete.
 ** Based on known deaths as of September 30, 2000.

Table 2. Cases of gonorrhea by county of residence at diagnosis, AIDSNET Region 6, 1981-1999

COUNTY	YEAR																	
	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
Clallam	111	72	74	58	43	38	22	20	4	10	13	6	12	9	3	8	3	3
Clark	549	461	475	501	382	265	193	154	168	146	139	91	80	94	95	45	71	87
Cowlitz	125	156	236	285	143	94	36	10	29	37	61	17	6	6	6	2	2	12
Grays Harbor	105	112	48	51	66	65	43	36	15	14	10	12	34	22	18	12	3	3
Jefferson	10	5	5	1	5	8	3	9	1	5	1	1	2	1	0	2	2	1
Lewis	93	74	42	31	42	61	21	29	42	35	19	13	3	18	15	8	9	6
Mason	42	25	24	10	23	23	12	12	11	7	10	16	5	9	7	4	5	11
Pacific	10	5	13	9	9	5	3	4	1	2	2	1	1	7	2	5	3	0
Skamania	6	4	2	3	2	0	3	2	3	0	1	0	1	0	0	0	0	0
Thurston	225	177	150	143	116	142	98	98	77	55	43	41	33	67	45	24	28	37
Wahkiakum	1	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1277	1095	1071	1092	831	701	434	374	351	311	299	198	177	233	191	110	126	160

Table 3. Cases of hepatitis B by county of residence at time of diagnosis, AIDSNET Region 6, 1988-1999

COUNTY	YEAR												
	88	89	90	91	92	93	94	95	96	97	98	99	
Clallam	13	21	13	9	4	4	1	4	2	2	1	0	
Clark	42	42	30	52	51	34	16	29	17	11	18	10	
Cowlitz	30	46	47	68	29	18	11	4	5	5	4	4	
Grays Harbor	36	21	24	17	6	8	15	13	5	4	2	0	
Jefferson	1	0	1	1	1	2	0	3	0	0	0	0	
Lewis	9	13	8	6	7	2	3	2	0	1	2	1	
Mason	22	19	7	8	7	4	8	3	5	5	2	1	
Pacific	4	5	12	2	0	1	5	2	1	1	0	0	
Skamania	0	0	1	0	0	1	1	2	1	0	0	0	
Thurston	23	35	12	13	5	4	16	6	1	1	0	2	
Wahkiakum	1	0	0	2	0	1	0	0	0	0	0	0	
TOTAL	181	202	155	178	110	79	76	68	37	30	29	18	

Table 4. Pregnancies (including abortions and births) among women 15-17 years of age by county of residence, AIDSNET Region 6, 1986-1998.

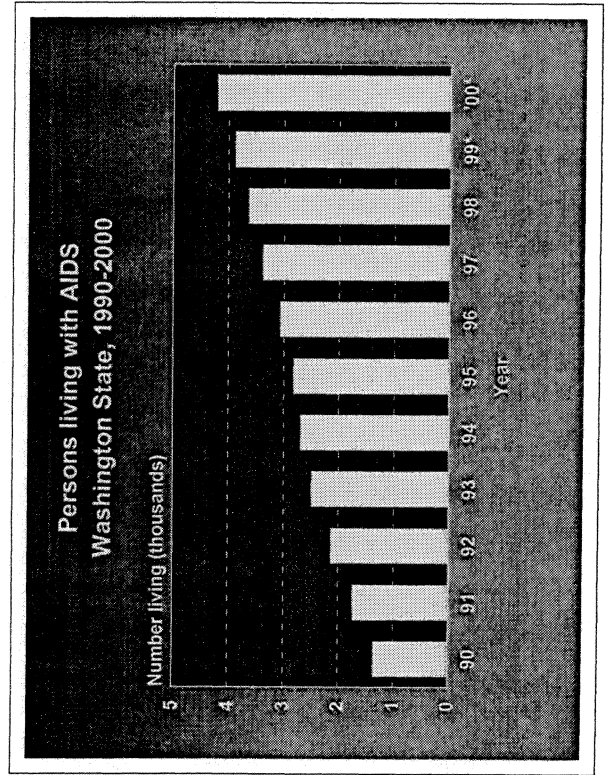
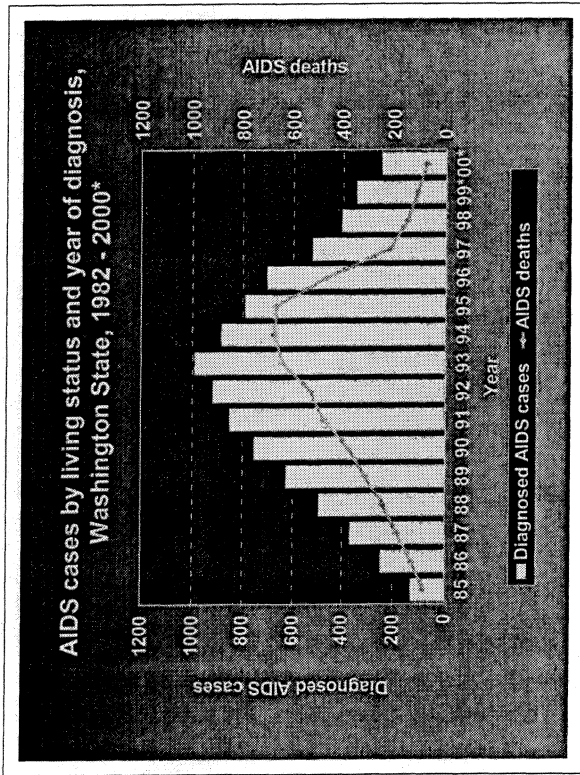
COUNTY	YEAR													
	86	87	88	89	90	91	92	93	94	95	96	97	98	
Clallam	37	89	44	53	70	64	57	42	37	53	51	46	65	
Clark	236	253	239	235	196	251	239	252	270	350	299	301	291	
Cowlitz	83	89	106	104	85	120	95	118	117	97	96	89	86	
Grays Harbor	96	107	94	96	97	87	95	86	72	82	81	92	89	
Jefferson	8	7	10	12	16	17	18	18	13	15	12	19	20	
Lewis	61	69	70	66	52	65	60	54	79	79	77	84	64	
Mason	34	36	40	44	77	45	41	54	51	56	51	49	58	
Pacific	16	13	18	21	19	17	22	29	19	21	14	20	16	
Skamania	8	14	13	12	5	2	5	5	5	8	5	8	9	
Thurston	170	191	192	187	174	174	191	175	176	167	172	207	189	
Wahkiakum	2	3	3	4	3	2	4	1	1	3	1	4	4	
TOTAL	751	881	829	834	794	844	827	834	840	931	859	919	891	

**Epidemiology of HIV/AIDS in
Washington State:
Successes, Challenges, and New
Developments**

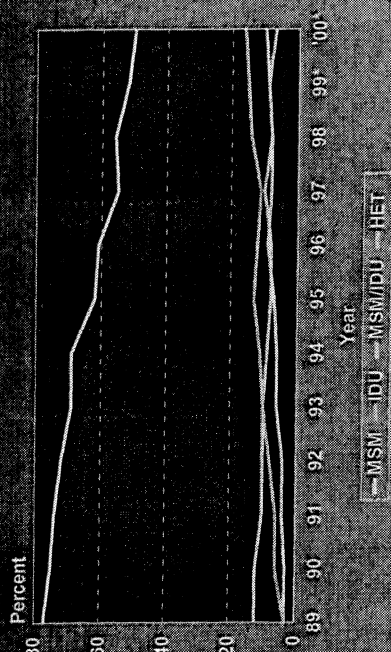
March 2001

What's new in 2000?

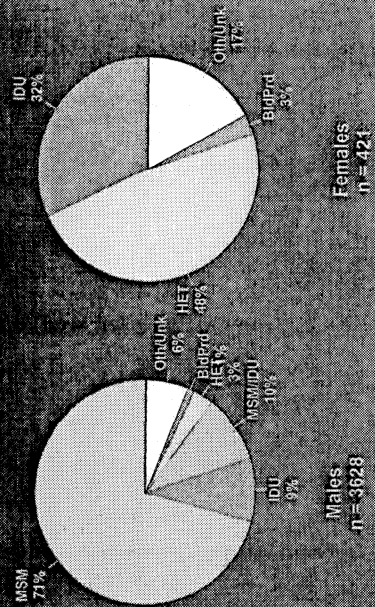
- Stalling of trends in AIDS incidence and AIDS deaths
- Initiation of HIV surveillance in September 1999
- Shifts in the epidemic, as well as increasing concern about traditional risk populations
- New HAART recommendations
- Focus on prevention in those who are HIV+

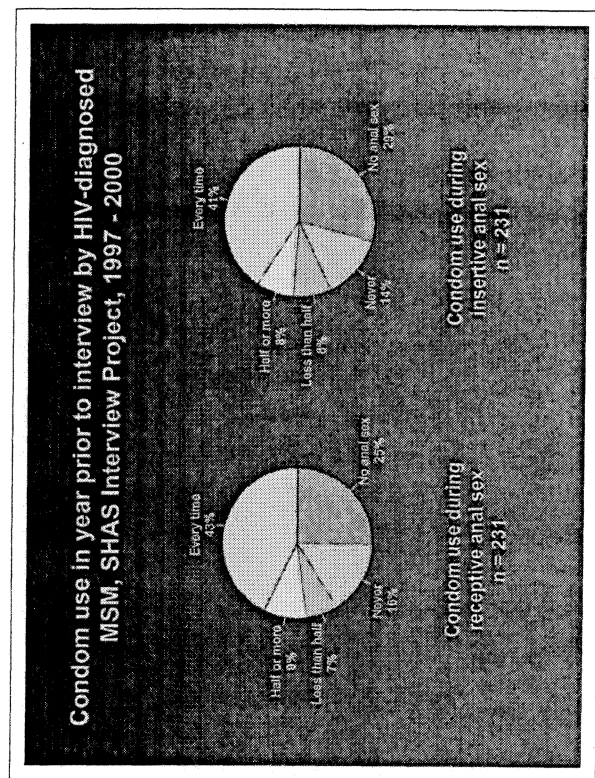
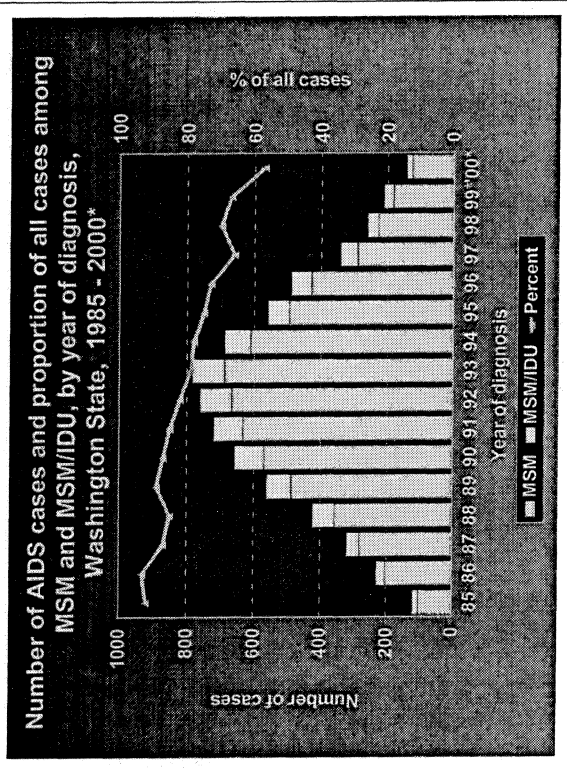


Proportion of AIDS cases accounted for by selected HIV exposure groups, Washington State, 1989 - 2000*
Washington State, 1989-2000*

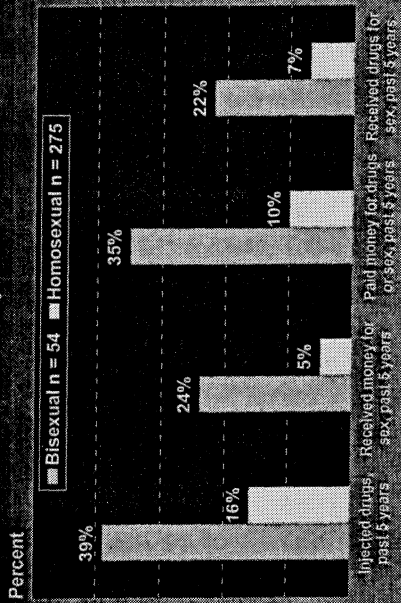


Adults and adolescents living with AIDS, by exposure category, Washington State





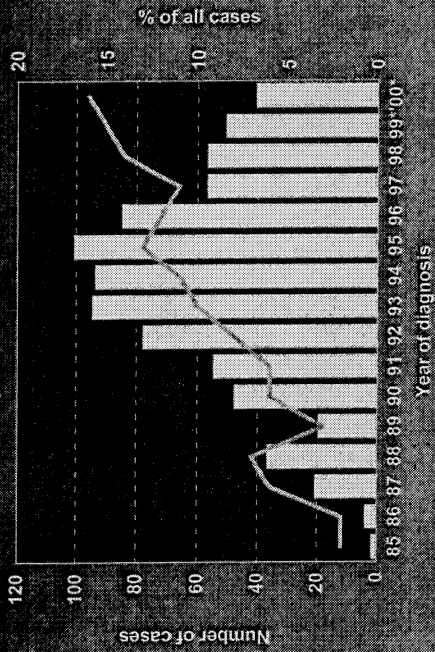
Sexual and drug using behaviors among men with HIV
by sexual activity, 1997 - 2000



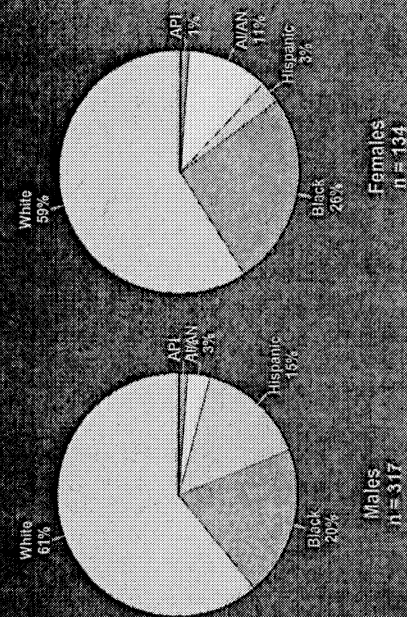
MSM

- HIV prevalence appears to be increasing in King County
- Persistent STD outbreaks in MSM in King County
- Various studies demonstrate continuing high risk behavior
- Seroprevalence in MSM who inject, especially methamphetamines, is higher
- Young MSM Study - 2% seroprevalence in 15-22 year olds, 5% in those 23-29, high proportion of high risk behaviors

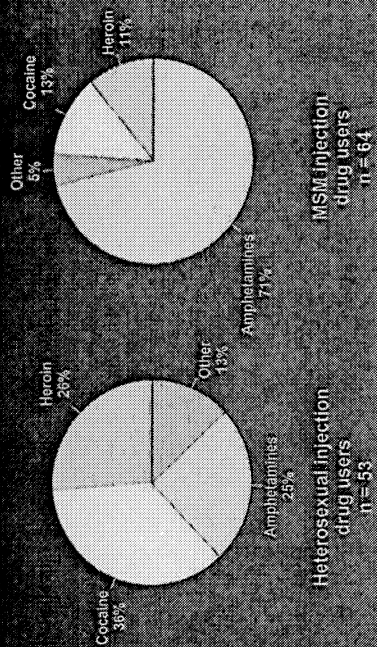
Number of AIDS cases and proportion of all cases among female and heterosexual male IDUs, by year of diagnosis, Washington State, 1985 - 2000*



Female and heterosexual male IDUs living with AIDS, by gender and race/ethnicity, Washington State



Type of drug injected most often by injection drug users, 1997 - 2000



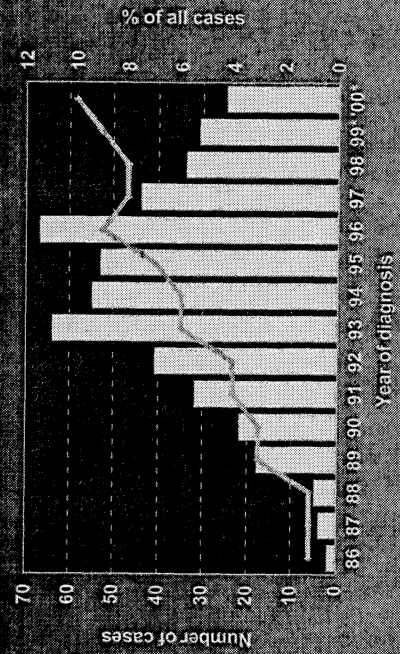
For respondents who had injected in 5 years prior to interview, 1997-2000, n = 117

- 67% had shared needles in the 5 years prior to interview
- 55% had ever used a needle exchange
- 27% usually got their needles from a needle exchange, 18% from pharmacies, 21% from friends, 15% from shooting partners, 8% from the person who sells them drugs, and 10% from other sources

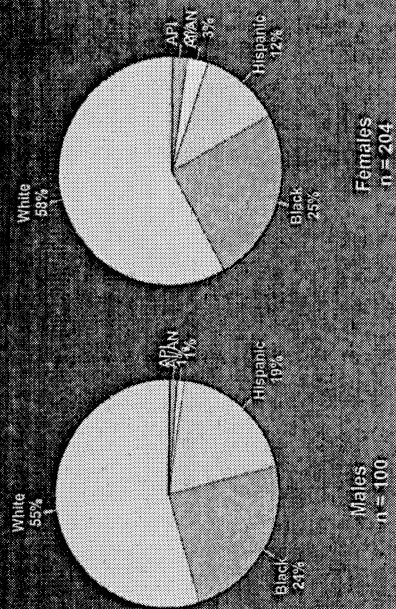
IDU

- Stable seroprevalence at drug treatment centers (2%)
- IDUs recruited in other settings (jail, needle exchange) had seroprevalence 2x higher
- Proportion of AIDS cases due to IDU is higher in African Americans and Native Americans
- Of 1,842 people tested for HIV during hepatitis outbreak in Pierce County, 20 (1.1%) tested HIV+

Number of AIDS cases and proportion of all cases due to heterosexual transmission, by year of diagnosis, Washington State, 1986 - 2000*



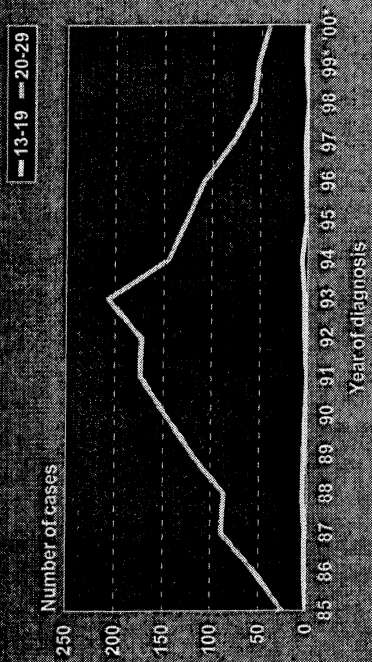
Cases due to heterosexual contact, living with AIDS, by gender and race/ethnicity, Washington State



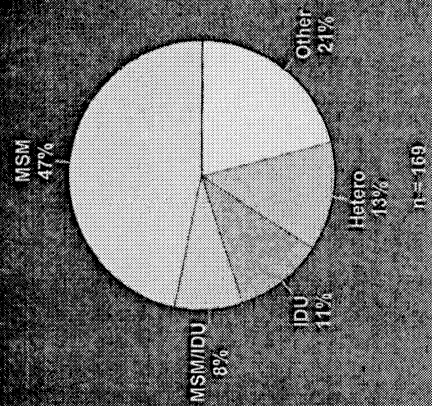
Heterosexual transmission

- Continued low seroprevalence in studies
- Higher proportions are young, women, people of color
- As more men who are bisexually active or inject drugs become infected, an increasing percentage of women are infected heterosexually

AIDS cases among adolescents and young adults by year of diagnosis, Washington State, 1985 - 2000*



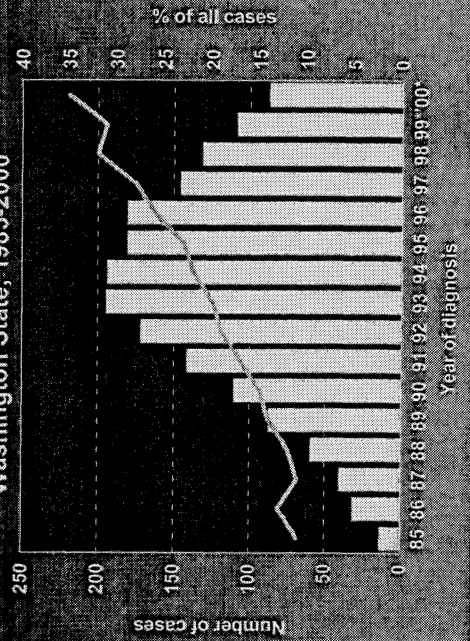
Adolescents and young adults living with AIDS, 13-24 years of age, by mode of transmission



Adolescents and young adults

- Young people make up a small percentage of people living with HIV and AIDS; however, they do engage in risky behaviors as shown by STD data
- The predominant mode of HIV transmission in people between the ages of 13 and 24 years is MSM (47%)

Number of AIDS cases and proportion of all cases among people of color by year of diagnosis, Washington State, 1985-2000*



**AIDS cases and case rates by race/ethnicity,
Washington State, 1997 - 1999**

Race/ethnicity	Number of Cases	Rate*
White	895 (70%)	18.9
Black	177 (14%)	96.3
Hispanic	137 (11%)	39.9
Asian/Pacific Islander	25 (2%)	7.8
AmerInd/AlaskNat	42 (3%)	45.3

*Cases per 100,000 population in 1998.

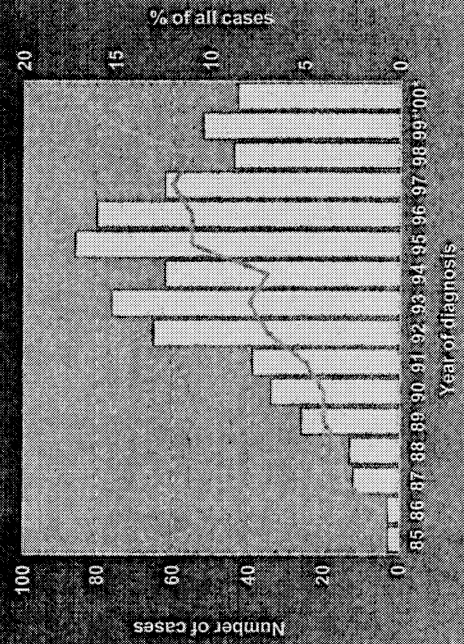
**SHAS data can help identify populations who
are being misclassified in the surveillance system**

- Race/ethnicity data are collected on both the HIV/AIDS case report and in the SHAS interview.
- Data on the cases report are often obtained from medical records or via provider report. Data in SHAS are self-reported.
- When comparing racial/ethnic classification in the two systems, it was found that those who self-identify as American Indian/Alaska Native were often misclassified (in 39% of cases). They were most often misclassified as white (28%). Hispanics were also often misclassified as white (17%).

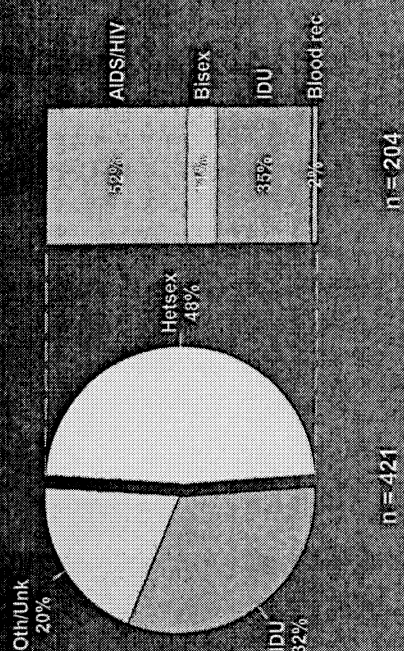
People of color

- Higher disease rates, particularly in African Americans
- Higher proportion of AIDS cases in African Americans and Native Americans due to injection drug use
- Proportion of African Americans living with AIDS is highest in Region 5 (20%) and proportion of Hispanics living with AIDS is highest in Region 2 (38%)

Number of AIDS cases and proportion of all cases among women, by year of diagnosis, Washington State, 1985-2000*



Women living with AIDS, by HIV exposure category,
Washington State



Women

- Disease rates often higher in younger women
- Disease rates in women of color, particularly African American women, are higher than in white women
- Injection drug use mode of transmission for higher proportion of African American and Native American women than other races

**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 4

**GAP ANALYSIS
GUIDANCE**

WASHINGTON STATE HIV PREVENTION PLANNING GAP ANALYSIS MODEL

Developed by:

**Gap Analysis Committee of the State Planning Group
John Peppert, Kerri Mallams, Wendy Doescher, Alex
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Department of Health staff: Ellen Hepp and Nancy Hall**

Gap Analysis Guidance

Introduction

In order to set priorities regarding interventions for target populations, it is important that we have a method of obtaining and analyzing information to determine the current status and service needs of a defined population. We must also be aware of the current prevention services and resources that are available, as well as, the extent to which prevention needs of target populations remain unmet. A prevention need is a documented necessity for HIV prevention services within a specific target population based on the numbers, proportions, or other estimates of the impact of HIV or AIDS among this population from the epidemiologic profile. It also is based on information showing that members of this population are engaging in behavior that places them at high risk for HIV transmission (AED).

A met need is a requirement for HIV prevention services within a specific target population that is currently being addressed through existing HIV prevention resources that are available to, appropriate for, and accessible to that population (AED).

An unmet need is a requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are currently available or because available services are either inappropriate for, or inaccessible to the target population (AED).

While the essence of the gap analysis is to identify unmet needs, we must also make sure that we don't eliminate existing resources that are meeting critical needs. Therefore, in the prioritization process we must include both met and unmet prevention needs. The intention is NOT to create new gaps!

The gap analysis should identify and prioritize the unmet needs for HIV prevention services for each high-risk target population and sub-population in each of the six AIDSNET regions. It will also identify the existing services and resources available for each of these groups.

Steps in Conducting the Gap Analysis

The first step of this process involves the completion of Attachment I: "Prevention Needs Table" or 'needs matrix'. The table addresses three Behavioral Risk Categories: MSMs, IDUs and Heterosexuals-at-risk. The intention is to target high-risk populations identified in the epidemiologic profile. Other epidemiological data such as race or ethnicity, gender, age, and risk behavior is also significant in the identification of specific populations. It is also important to look at surrogate measures including substance abuse

data, unemployment information, STD rates, teen pregnancy rates, income and poverty levels, etc. that may help identify trends in HIV risk behavior among specific populations.

For each target population there are three categories of Prevention Needs: Knowledge, Attitudes/Beliefs, and Behavior/Skills. These concepts, as well as others, play a crucial role assessing prevention needs. For each of these categories there are 5-7 statements that reflect that particular prevention need. Several of these statements are further described after each section and are marked by asterisks. These clarifications are provided to help you in this process. Please do not feel limited by these suggestions. Your group will probably generate additions to our suggestions that will be extremely helpful for future planning.

This table is not merely a checklist. It is the responsibility of all RPG members to utilize multiple sources of information in order to gain a comprehensive and accurate understanding of the HIV prevention needs of each target population. These include, but are not limited to-

1. surveys
2. focus groups
3. current research findings
4. individual key informant interviews
5. community forums and public meetings
6. HIV-positive individuals from target population
7. HIV-negative individuals from target population
8. community-based prevention providers
9. health department staff
10. other experts

It may become apparent during the course of completing this table that your RPG is unable to answer some of the questions addressed due to a lack of data. It may be necessary to initiate a needs assessment or other data gathering to obtain the information that is missing.

In completing the Prevention Needs Table it is imperative that you work DOWN one column at a time and complete that column in its entirety before moving on to the next column. For each response there is a space below for brief comments. It may be necessary to use additional paper when applicable. Use this space also to note any discrepancies among needs of various subpopulations. It will be helpful to also note barriers as you identify them.

As you proceed through this task keep in mind the importance of documenting and qualifying your responses. How you reached your conclusions and recommendations may be as or more important than what they finally are.

Working through the Prevention Needs Table

Select a target population to begin with. For each target population, briefly summarize HIV/AIDS case numbers, proportions, sociodemographic characteristics, and any other factors that may affect the level of risk. For those of you that have done a prioritization of subpopulations it will be useful to consider each of the subpopulations as you address each question. If you have not prioritized subpopulations, please be sure that you at least take into account the differences among subpopulations regarding prevention needs and access issues.

Begin with the first vertical column.

- How much of the target population possesses this information?
Although it may be impossible to account for all individuals, make sure that you can safely make a generalization for the target population. This may require additional focus groups, surveys, etc. Be sure to document the sources used for this determination.
- How do resources, services and policies outside of your direct control affect this need?
Many aspects of wide-ranging systems have anywhere from a little to a tremendous impact on HIV prevention. It is important to recognize these valuable assets and identify the role that they play in meeting HIV prevention needs.
*Before beginning this column you will need to generate a list that will allow you to complete the column in a more efficient manner. As a group, brainstorm and list any and all resources, services and policies that may have an impact on HIV/AIDS knowledge, attitudes/beliefs, or behavior/skills AND are not controlled by you in terms of policy, funding or programming. Consider media and public service announcements, hotlines, state and local legislative policies, school-based programs, gang prevention programs, drug treatment programs, family planning programs, support groups, religious-based interventions and activities, and community attitudes, values and norms as examples.
After making your list, describe which target population(s) are impacted and a brief description of the effects that result. Positive, negative and neutral impact should all be recognized.
Please remember NOT to include any resources or services that you control by policy, programs or funding in this category.
- How do existing HIV resources currently address this need?
This section deals with all of the HIV prevention resources and interventions that are listed in the Community Resource Inventory (CRI) for your region.
Please consider the following factors as you proceed with this step.
 1. What barriers to accessing or using prevention services do members of the target population experience or perceive? (language, transportation, hours of availability, etc.)

2. What interventions have been documented to work best with the target population?
3. What HIV prevention services are available, accessible and appropriate for this population?
4. What subpopulations is this intervention appropriate for? Which subpopulations require critical elements that are not provided by this intervention?

➤ How would funding loss impact on this prevention need?

This refers to the funding that is provided for interventions listed in the CRI. If this funding were no longer available, how would this affect each particular prevention need? You must determine the priority for continuing interventions in order to maintain or increase the level of knowledge, attitudes and beliefs, and behaviors and skills. If resources and services are operating exclusive of your funding, and are fulfilling areas of critical need, then a funding loss controlled by you for that particular intervention would be minimal.

Now that you have completed these four columns, you have identified a lot of information. You should have established the following factors:

1. Total HIV/AIDS cases by target populations and subpopulations
2. Estimation of need for prevention services for the target populations. In regard to knowledge, attitudes/beliefs, and behavior/skills, you have documented areas of deficits and sufficiency.
3. Identification of resources and services that do not utilize your funding- Some or many of these may serve to satisfy HIV prevention needs and allow for reallocation of resources that demand greater priority.
4. In looking at the interventions present in your region you have examined and summarized for each target population:
 - a. barriers to accessing HIV prevention services such as language, culture, transportation, location, hours of operation, etc.
 - b. identification of interventions that are most appropriate in terms of culture, race/ethnicity, sexual orientation, age, gender, risk behavior, and any other necessary considerations
5. Consideration of how the impact of loss of funding would affect the prevention needs that are currently being met

The next step in this process is to identify the unmet needs. Before proceeding any further, all members should engage in a thorough brainstorming activity. Produce a random list of all and any ideas that come up during this process even if there is no conceivable way that we could meet this need.

Go on to complete the darkest shaded column of the Needs Prevention Table.

➤ Is this an unmet need?

Using all of the information that you have compiled in the first four columns, you will be able to address this question. For example, if “a lot” of the target population knows the behaviors that transmit HIV and there are “enough” existing resources

currently addressing this need, then this would be considered a “minimal” unmet need. For subpopulations that may present an exception to the rule, make sure to make a notation in the brief comments space in the table.

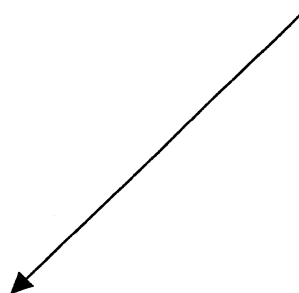
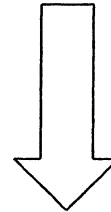
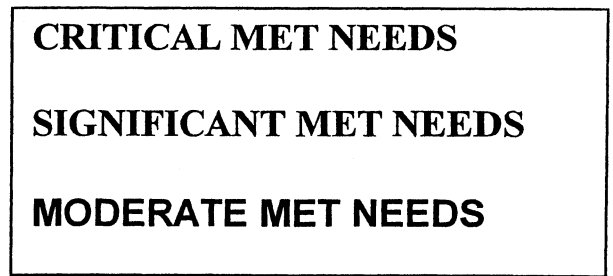
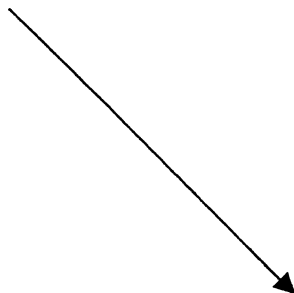
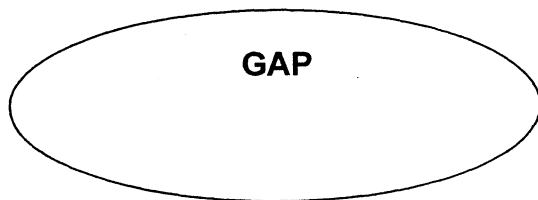
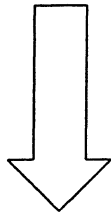
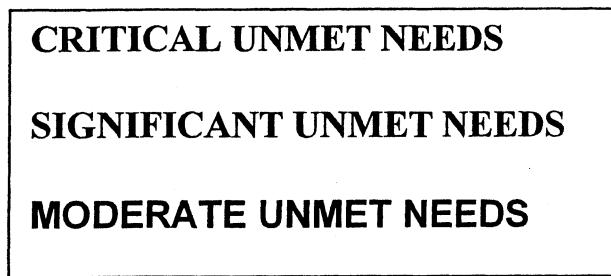
- What is the priority of funding interventions based on this prevention need?
We are now looking at the bigger picture. Be extremely cautious as you make these determinations. For instance, if you have identified that “enough” of the target population knows that HIV is a potentially life threatening disease AND there are currently “enough” outside resources addressing this concern, then it is probably a “minimal” priority for funding. However, if you are aware of a certain subpopulation that is underestimating the impact of HIV due to a lack of language-appropriate communication and materials, it must not be overlooked. Be sure to specify any particular concerns that you see as needing further attention.

It is also critical that you identify not only the unmet needs, but the met needs as well as you undergo the process of prioritization for funding. Remember that we do not want to shift resources only to create new gaps!

After completing this final column of the Prevention Needs Table, it is time to take a good look at what you have determined. Examine and list your **critical unmet needs** first. This is your most urgent gap. Next, list your **critical met needs**. These are the services that are currently in place and will leave a new critical gap if they are removed. Repeat this step for the significant unmet and met needs, followed by the moderate unmet and met needs.

Once your list is completed, develop a prioritized list of unmet needs and recommendations of how those needs might be met, i.e. implementation of an identified effective intervention; capacity building in the community, etc. If a high priority unmet need cannot be effectively addressed, be sure to explain why and the rationale for not shifting resources to address that need.

Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups. Washington DC: Academy for Educational Development, August 1999.



ATTACHMENT I: PREVENTION NEEDS TABLE

Target Population: MSM

Prevention Need: Knowledge

Prevention Need Knowledge (MSM)	How much of the target population possesses this information?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. HIV is a potentially life threatening disease	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Knowledge of the behaviors that transmit HIV*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Knowledge of HIV status	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

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Prevention Need Knowledge (MSM)	How much of the target population possesses this information?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
4. Knowledge of HIV prevention**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Where to go for services, resources and social support***	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
6. Access to culturally and linguistically appropriate and competent interventions	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

*Knowledge of the behaviors that transmit HIV

HIV is transmitted through unprotected anal and oral intercourse

Having multiple sexual partners increases the chance of being exposed to a person infected with HIV

Participation in certain behaviors increases the risk of HIV infection

- ** Knowledge of HIV prevention
 - Safer sex practices
 - How to use condoms
- *** Where to go for services, resources and social support
 - Where to obtain risk reduction counseling services
 - Where to go for CTRPN
 - Where to obtain condoms
 - Availability of supplementary services and social support for safe housing, health care, child care, food, clothing, alcohol/drug treatment, mental health and/or domestic violence issues

Target Population: MSM
Prevention Need: Attitudes/Beliefs

Prevention Need Attitudes/Beliefs (MSM)	How much of the target population holds these attitudes/beliefs?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. Perceived susceptibility and vulnerability*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Motivation, intention and commitment to reduce high risk behaviors and increase low risk activities	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Increased self-esteem and confidence that one can utilize risk reduction behaviors consistently and under a variety of circumstances	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical

Prevention Need Attitudes/Beliefs (MSM)	How much of the target population holds these attitudes/beliefs?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
Brief comments						
4. Awareness of social influence and social norms that impact HIV transmission**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Sense of personal responsibility to not transmit HIV to others	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

*Perceived susceptibility/vulnerability

Believing that one is personally susceptible to contracting HIV

Concern about getting HIV/AIDS

Belief that acquiring HIV/AIDS is undesirable

**Awareness of social influence and social norms

Awareness of various obstacles that may present additional barriers to risk reduction including cultural or traditional roles (reduced power/choice), basic survival needs, effects of domestic

violence, hopelessness, drug addiction, distress, depression

Feeling connected to a supportive environment that encourages increased pride, self-identity and

decreased perceptions of discrimination & stigmatization

Ability to view avoidance of risk behavior as the accepted standard among peers and reinforced by

those around me

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Target Population: MSM
Prevention Need: Behavior/Skills

Prevention Need Behavior/Skills (MSM)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. Identification of high risk behaviors and ability to assess own risk of infection	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Use of risk reduction practices*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Use of communication skills that reduce HIV transmission**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

Prevention Need Behavior/Skills (MSM)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
4. Use of problem solving and decision making skills that reduce HIV transmission***	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Level of peer support for behavior change	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
6. Level of norms regarding acceptability of insisting on safer sex	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

Prevention Need Behavior/Skills (MSM)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
7. Level of maintenance of consistent behavior change	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

***Risk reduction practices**

- Consistent and proper condom use
- Reduce frequency of unprotected insertive & receptive anal intercourse
- Reduce number of sexual encounters & number of sex partners
- Eroticism of condom use
- **Communication skills
- Communication of HIV status with partners
- Discussion of safer sex with partners
- Sexual negotiation skills/sexual assertiveness/empowerment
- Refusal skills/ increased skills to resist peer pressure to engage in risk behaviors
- ***Problem solving and decision making skills
- Skills to reduce levels of distress and depression
- Stress management interventions and coping resources
- Consideration of pros and cons/ benefits and costs

Target Population: Injection Drug Users
Prevention Need: Knowledge

Prevention Need Knowledge (IDU)	How much of the target population possesses this information?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. HIV is a potentially life threatening disease	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Knowledge of the behaviors that transmit HIV*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Knowledge of HIV status	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

Prevention Need Knowledge (IDU)	How much of the target population possesses this information?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
4. Knowledge of HIV prevention**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Where to go for services, resources and social support***	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
6. Access to culturally and linguistically appropriate and competent interventions	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
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- *Knowledge of HIV transmission
 - HIV is transmitted through sharing needles, syringes and works
 - HIV is transmitted through unprotected vaginal, anal and oral intercourse
 - Having multiple drug injection or sexual partners increases the chance of being exposed to a person infected with HIV
 - Participation in certain behaviors increases the risk of HIV infection
- **Knowledge of HIV prevention
 - How to clean works
 - How to obtain sterile needles & syringes
 - Safer sex practices
 - How to use condoms
- ***Where to go for services, resources and social support
 - Where to obtain risk reduction counseling services
 - Where to go for CTRPN
 - Where to access sterile syringes or syringe exchange
 - Where to access drug treatment (on demand)
 - Where to obtain condoms
 - Availability of supplementary services and social support for safe housing, health care, child care, food, clothing, alcohol/drug treatment, mental health and/or domestic violence issues

Target Population: Injection Drug Users
Prevention Need: Attitudes/Beliefs

Prevention Need Attitudes/Beliefs (IDU)	How much of the target population holds these attitudes/beliefs?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. Perceived susceptibility and vulnerability*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Motivation, intention and commitment to reduce high risk behaviors and increase low risk activities	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Increased self-esteem and confidence that one can utilize risk reduction behaviors consistently and under a variety of circumstances	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical

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Prevention Need Attitudes/Beliefs (IDU)	How much of the target population holds these attitudes/beliefs?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
Brief comments						
4. Awareness of social influence and social norms that impact HIV transmission**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Sense of personal responsibility to not transmit HIV to others	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

*Perceived susceptibility/vulnerability

Believing that one is personally susceptible to contracting HIV

Concern about getting HIV/AIDS

Belief that acquiring HIV/AIDS is undesirable

** Awareness of social influence and social norms

Awareness of various obstacles that may present additional barriers to risk reduction including

cultural or traditional roles (reduced power/choice), basic survival needs, effects of domestic

violence, hopelessness, drug addiction, distress, depression

Ability to view avoidance of risk behavior as the accepted standard among peers and reinforced by those around me

Feeling connected to a supportive environment that encourages increased pride, self-identity and

decreased perceptions of discrimination & stigmatization

**Target Population: Injection Drug Users
Prevention Need: Behavior/Skills**

Prevention Need Behavior/Skills (IDU)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. Identification of high risk behaviors and ability to assess own risk of infection	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Use of risk reduction practices*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Use of communication skills that reduce HIV transmission**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

Prevention Need Behavior/Skills (IDU)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?	
4. Use of problem solving and decision making skills that reduce HIV transmission ***	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	
Brief comments							
5. Level of peer support for behavior change	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	
Brief comments							
6. Level of norms regarding acceptability of insisting on safer sex	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>	Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical <input type="checkbox"/>
Brief comments							

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Prevention Need Behavior/Skills (IDU)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
7. Level of maintenance of consistent behavior change	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

*Risk reduction practices

Reducing or eliminating injection

Cleaning works

Use of new sterile needles, syringes

Participation in syringe exchange

Consistent and proper condom use

**Communication skills

Communication of HIV status with partners

Discussion of safer sex with partners

Negotiation and assertiveness skills

Refusal skills/ increased skills to resist peer pressure to engage in risk behaviors

***Problem solving and decision making skills

Skills to reduce levels of distress and depression

Stress management interventions and coping resources

Consideration of pros and cons/ benefits and costs

**Target Population: Heterosexuals at Risk
Prevention Need: Knowledge**

Prevention Need Knowledge (Heterosexuals)	How much of the target population possesses this information?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. HIV is a potentially life threatening disease	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Knowledge of the behaviors that transmit HIV*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Knowledge of HIV status	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

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Prevention Need Knowledge (Heterosexuals)	How much of the target population possesses this information?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
4. Knowledge of HIV prevention**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Where to go for services, resources and social support***	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
6. Access to culturally and linguistically appropriate and competent interventions	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

*Knowledge of HIV transmission
 HIV is transmitted through unprotected vaginal, anal and oral intercourse
 Having multiple sexual partners increases the chance of being exposed to a person infected with HIV
 Participation in certain behaviors increases the risk of HIV infection

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- **Knowledge of HIV prevention
 - Safer sex practices
 - How to use condoms
- ***Where to go for services, resources and social support
 - Where to obtain risk reduction counseling services
 - Where to go for CTRPN
 - Where to obtain condoms
 - Availability of supplementary services and social support for safe housing, health care, child care, food, clothing, alcohol/drug treatment and/or domestic violence issues

**Target Population: Heterosexuals at Risk
Prevention Need: Attitudes/Beliefs**

Prevention Need Attitudes/Beliefs (Heterosexuals)	How much of the target population holds these attitudes/beliefs?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. Perceived susceptibility and vulnerability*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Motivation, intention and commitment to reduce high risk behaviors and increase low risk activities	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Increased self-esteem and confidence that one can utilize risk reduction behaviors consistently and under a variety of circumstances	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

Prevention Need Attitudes/Beliefs (Heterosexuals)	How much of the target population holds these attitudes/beliefs?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
4. Awareness of social influence and social norms that impact HIV transmission**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Sense of personal responsibility to not transmit HIV to others	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

* Perceived susceptibility/vulnerability

Believing that one is personally susceptible to contracting HIV

Concern about getting HIV/AIDS

Belief that acquiring HIV/AIDS is undesirable

** Awareness of social influence and social norms

Awareness of various obstacles that may present additional barriers to risk reduction including cultural or traditional roles (reduced power/choice), basic survival needs, effects of domestic violence, hopelessness, drug addiction, distress, depression

Ability to view avoidance of risk behavior as the accepted standard among peers and reinforced by those around me

Feeling connected to a supportive environment that encourages increased pride, self-identity and decreased perceptions of discrimination & stigmatization

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**Target Population: Heterosexuals at Risk
Prevention Need: Behavior/Skills**

Prevention Need Behavior/Skills (Heterosexuals)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
1. Identification of high risk behaviors and ability to assess own risk of infection	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
2. Use of risk reduction practices*	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
3. Use of communication skills that reduce HIV transmission**	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

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Prevention Need Behavior/Skills (Heterosexuals)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
4. Use of problem solving and decision making skills that reduce HIV transmission***	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
5. Level of peer support for behavior change	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						
6. Level of norms regarding acceptability of insisting on safer sex	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

Prevention Need Behavior/Skills (Heterosexuals)	How much of the target population practices this behavior/skill?	How do resources, services and policies outside of your direct control affect this need?	How do existing HIV resources currently address this need?	How would funding loss impact on this prevention need?	Is this an unmet need?	What is the priority of funding interventions based on this prevention need?
7. Level of maintenance of consistent behavior change	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Some <input type="checkbox"/> A lot <input type="checkbox"/> Enough	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical	<input type="checkbox"/> Minimal <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Critical
Brief comments						

*Risk reduction practices

Consistent and proper condom use

Reduce number of sexual encounters & number of sex partners

Eroticism of condom use

**Communication skills

Communication of HIV status with partners

Discussion of safer sex with partners

Sexual negotiation skills/sexual assertiveness/empowerment

Refusal skills/ increased skills to resist peer

***Problem solving and decision making skills

Skills to reduce levels of distress and depression

Stress management interventions and coping resources

Consideration of pros and cons/ benefits and costs

**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 5

**PUBLIC HEALTH
PERSPECTIVE
KAB PRESENTATION
INFORMATION
MSM/STD/HIV SUMMIT
SUMMARY
YOUNG MEN'S STUDY**

The PUBLIC HEALTH Perspective

Prevention Prioritization for 2002-03

February 12, 2001

Background/Purpose

The HIV/AIDS Planning Council's Prevention Planning Committee has requested, for its decision-making processes on prevention priorities, recommendations from Public Health – Seattle & King County, based on public health science.

This document provides our perspective and recommendations on the best use of limited resources for the prevention of HIV infection. We include:

- Basic public health disease prevention principles which the Planning Council's Prevention Planning Committee may wish to consider;
- Our answers to questions posed to us, and;
- Citations relevant to the principles and the answers to the Committee's questions.

Our statements and recommendations are simply what we as public health professionals believe to be true and advisable. Suggestions are non-binding and are intended to provide a starting point for committee dialogue, and to strengthen the coordination between the Council's prevention prioritization processes and the ones annually performed by Public Health.

Basic Principles

1. The role of public health (as opposed to individual health care) is to prevent and control disease and to assure access to high quality needed care in groups/populations of people, through the use of epidemiology, planning, evaluation, implementation, and monitoring.
2. Not all individuals are at equal risk of transmitting or acquiring communicable diseases. A number of studies involving a number of communicable diseases (including vector-borne parasitic diseases [e.g., malaria], and sexually transmitted diseases), suggest that a “core” group of typically 20% of individuals contributes at least 80% of the net transmission potential for a disease.^{1*}
3. HIV prevention resources should be focused on particular segments of the population that can be shown to be at high risk of transmitting or acquiring HIV, rather than distributed evenly across the entire population, because focused efforts will have greater effects per intervention cost on disease prevention.² Local epidemiologic data, including AIDS and HIV surveillance, and data on risk behavior in specific populations should be strongly used to focus efforts.[†]
4. Resources for HIV prevention are in short supply; and prevention resources are smaller than those available for HIV/AIDS care.³ Thus, there are not sufficient resources to optimally prevent HIV transmission even within the population segments at highest risk, and their use must be carefully prioritized.
5. Best (the most cost- and outcome-effective) strategies for reducing behavior risk vary by target group. Best strategies depend on such factors as:
 - the *risk behaviors* (e.g., sexual risk reduction among men who have sex with men [MSM] require different strategies than safer needle use by injection drug users [IDU]);
 - *co-morbidities* (the presence of multiple diagnoses/problems, e.g., persons with substantial mental illness or substance addiction would need different prevention strategies than those without these additional problems);
 - *age* (e.g., older MSM will likely require different strategies than younger MSM);
 - *time* (e.g., young MSM today probably need different strategies than young MSM in early years of the AIDS epidemic; older MSM who may be “burned out” on HIV/AIDS prevention messages will need strategies from those used in earlier years);
 - *race and ethnicity* (e.g., non-English-speaking clients need special brochures);

* For example, a study from France showed that only 13% of the adult population had any new sexual partners during a one-year period and thus could have made any substantial contribution to the transmission of HIV.

† In terms of the “fire analogy” discussed in Committee meetings (see appendix), a fire chief with 10,000 gallons of water to apply to prevent spread of fire might first soak any surrounding structures in danger of igniting, then quell the fire, rather than directing the water to be evenly distribute over the entire community.

- *socio-economic status* (e.g., persons who have no expectation of being able to access expensive health care may need special messages assuring them that anti-retroviral drugs are truly available to them before they will seek to be tested for HIV);
 - *locale* (e.g., urban multiple-partnered heterosexuals would be reached differently than rural ones);
 - *stage of change in risk reduction* (e.g., persons who have not thought about using condoms require different strategies than those who intend to use condoms consistently); and by
 - *purpose* (e.g., whether their purpose is to initiate or maintain risk reduction).
6. Highest priority interventions target highest priority populations with strategies which meet the best criteria for effectiveness and cost-saving. Proven interventions are those known to be efficacious on a wide-scale basis (usually published in the scientific literature and widely accepted as effective). Promising interventions are those which have both a theoretical basis for efficacy and empirical evidence supporting at least some parts of the theoretical model.⁴ Many “possibly effective” interventions lack evidence of effect on disease outcome but use methods based on accepted theories/principles.
7. Often, by the time interventions shown to be effective are published, effectiveness may have changed. Best interventions are so dependent on social/cultural factors (which are constantly and rapidly changing), and rigorous testing of intervention leading to publications takes so long, that what once worked well may no longer be applicable. (This point was made at the 12/1/00 MSM-STD “Summit” Conference.)
8. Interventions are most effective when tailored to the population, sustained in adequate “doses” over time, consistent (or, better yet, “synergistic”) with other interventions, delivered at multiple levels,⁵ able to be readily adopted, and endorsed by respected leaders. Correlates of these “facts” include:
- HIV prevention agencies should work together to fashion similar, complementary, or linked messages and strategies, so that persons are impacted through multiple venues and at multiple levels (i.e., individual, interpersonal, institutional, community, and policy levels).⁶ Persons are most likely to reduce risk behaviors when impacted from the largest possible array of sources and at all levels (e.g., parents, physicians, teachers, and leaders all saying that smoking is harmful; prohibitions against smoking in workplaces, hospitals, airplanes; prohibitions against cigarette promotion; media campaigns to stop smoking).
 - Interventions that cannot be funded adequately to reach sufficiently large percentages of the target audience repeatedly over time will be unlikely to have an impact. E.g., only reaching 10% of the target population for a year would be hardly worth doing, while interventions proposing to reach 60% with multiple exposures for three years might be expected to have an impact.
 - Interventions need to promote “realistic” behavioral risk reduction steps. To know if a recommended strategy is “realistic”, focus group or other population testing is required.

- Respected community leaders need to be identified and recruited to enthusiastically support realistic risk reduction strategies.
 - Interventions must attend to aspects of the social context that may hinder or promote efforts at behavioral change and health risk reduction.⁷
9. Program evaluation is essential to knowing whether scarce resources are being optimally used, including measures of the processes of the interventions, their impacts on targeted populations, and outcomes.

Answers to the Prevention Committee's Specific Questions

Question 1: Which populations are at this point in the epidemic the most endangered, and why? In terms of our "fire analogy", (a) where is the fire burning? (b) Are there any "new fires"? (c) What population(s) are closest to the margin of the fire? What, in the assessment of Public Health, are the "high risk" populations, and why?

(a) Where is the fire burning?

Using our fire analogy, people with HIV infection are "on fire." (See appendix for a discussion of the fire analogy.) Those population groups with the highest HIV seroprevalence (percentage of people infected with HIV), which are listed here by risk behaviors, have the largest proportions already "on fire". They may be urban or rural, of any age or race/ethnicity:

1. Persons who know they have HIV (HIV+)

These persons are 100% infected with HIV. Although evidence shows that persons reduce risk behavior after learning they carry HIV, because they got infected in the first place, risk behavior may remain high in HIV-infected populations. For example, risk behavior of local HIV+ MSM appears to be greater than that reported by HIV-negative MSM.[†] Both a recent draft of the CDC's Five Year HIV Prevention plan,⁸ and a new book from the Institute of Medicine⁹ call for substantially increased HIV prevention efforts targeting persons with HIV.

2. Sex and needle-sharing partners (SNP) of HIV-infected individuals

These individuals, when reached in partner counseling & referral service (PCRS, see below) efforts, have been found to have high HIV seroprevalence rates. Partner notification is particularly cost-effective in lower HIV seroprevalence settings in locating and counseling unknowingly seropositive persons – from 10% to 35% of partners contacted & tested.^{10,11,12,13,14,15,16,17} In Sweden, PN is considered "one of the most efficient ways of finding persons who are unaware of their HIV serostatus".¹⁸ Only half of notified individuals are generally aware of their HIV infection status. Reaching these individuals through whatever means possible can be of life-saving importance to them.[§] The counseling with HIV testing has also been shown to substantially reduce their likelihood of their transmitting HIV to others.¹⁹ (Needle and injection equipment-sharing partners are themselves IDU and thus approached differently and covered below.)

3. Men who have sex with men and Inject Drugs (MSM – IDU)

About half of men who have sex with men and who inject drugs, primarily methamphetamine, are infected with HIV.²⁰

4. Men who have sex with men (MSM)

On average, we believe that about 14% of MSM are currently HIV-infected in the King County area. Within this group Black, Hispanic, and Native American MSM probably

[†] Higher rates of HIV risk behavior are documented in the "Sleepless in Seattle" cross-sectional study done locally in 1999-2000 involving nearly 1,000 MSM recruited from 4 sites (the STD Clinic, the HIV/AIDS program counseling & testing clinic, the Madison Clinic, and the offices of Drs. Shalit & Oliffe).

[§] For example, an HIV-infected with a CD4 [T4] cell counts less than 200 is at risk for *pneumocystis carinii* [PCP] pneumonia, a disease which kills 10% of people in its first episode, but which can be effectively prevented.

have higher rates of HIV infection than whites whose rates in turn are higher than Asian/Pacific Islanders' rates. Illicit drug use is high in this population, and several studies suggest that MSM who use drugs (particularly poppers and methamphetamines) are more likely to have HIV infection.

5. Injection Drug Users (IDU)

On average, about 3-4% are currently HIV-infected, a level of prevalence which has been stable for over a decade. However, the proportion of AIDS cases in IDU has been gradually rising. Also, Black, non-Hispanic and Hispanic clients entering drug treatment programs (in 1997-99) have shown higher rates of HIV infection than whites.²¹

HIGH HIV PREVALENCE POPS	% WITH HIV	COMMENTS:
HIV + Persons	100%	
Sex partners of HIV+s	20-40%	Half typically are not aware they have HIV
MSM-IDU	30-50%	
MSM, high risk subgroups:	14%	HAP Clinic data
MSM with Syphilis	75%	STD Clinic data
MSM with GC, Chlamydia	20%	STD Clinic data
MSM seen at STD clinic	6-11%	'98-'99 blinded STD seroprevalence data
23-25 yr. Old MSM	5%	YMS Study data
15-22 yr. Old MSM	2%	YMS Study data
MSM of color (Black & Latino)	??	HAP Clinic data show rates of positive tests nearly twice as high for Black & Latino as for white MSM from 1997-11/2000
MSM substance users	??	Local data not available
IDU	3-4%	RAVEN Study data

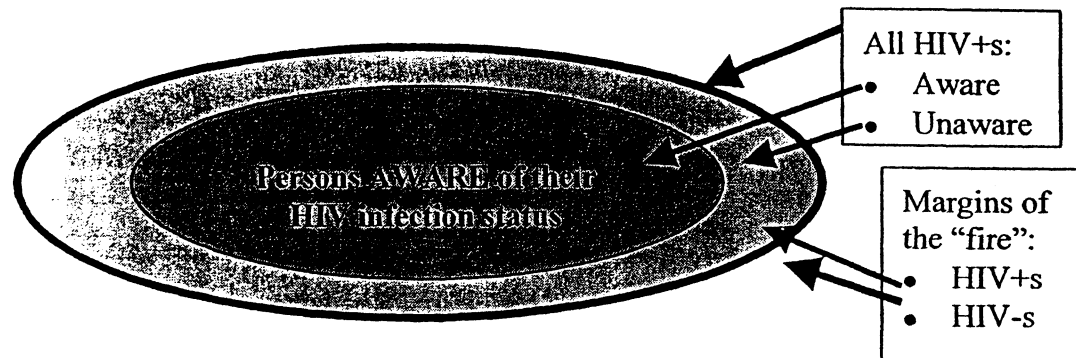
Note that we do not list as *high risk* any population segments with seroprevalence of less than 1%, which include most groups (e.g., women in general, or adolescents in general). The CDC considers any population with an HIV seroprevalence of at least 1% to be at high enough risk to recommend routinely offering HIV C/T (a specific and somewhat costly intervention), indicating their idea of a "cut-off threshold" for HIV interventions.²² Making HIV C/T routine for pregnant women (which have an HIV infection rate of much less than 1%) is justified by the specific and highly effective intervention (of providing at least AZT to the woman and the newborn around the time of delivery, which reduces the likelihood of her transmitting HIV to the infant by 66%²³) which makes testing very cost-effective in this setting.

(b) Are there any “new fires”?

“New fires” of HIV infection are new infections in persons and impacted groups. Data from the UW Primary Infection Clinic show that most newly infected persons have been and continue to be MSM, but there are too few newly identified cases (50 per year) to clarify which MSM or persons in other risk groups are at greatest risk. We hope that after HIV infection surveillance is in effect longer, capturing a larger number of recent infections, and after the HIV Incidence Study (HIVIS, designed to better characterize recently infected people) acquires more data, we will have better evidence about the recently infected “new fires.”

Some trend data should be noted. In all areas of the county HIV infection is clearly spreading from groups with higher levels of HIV infection (MSM, city dwellers, males) to less-impacted groups (heterosexuals, rural persons, and females). These trends, predicted long ago,²⁴ are occurring in King County more gradually than in many other areas of the country (see our answer to the Prevention Committee’s last question), because HIV infection was highly concentrated among MSM, and rates of infection in IDU have remained low. In other parts of the country, HIV transmission to and from IDU have been a main route of spread to heterosexuals and women and to children. Because the percentages of cases in these latter groups have been small, percentage increases are reported to be large (e.g., an increase from 1% to 2% is a [large]100% increase), but the absolute number of infected persons may still be low.

Probably the strongest local evidence of newly flaring fires is suggested by the recently increased cases of sexually transmitted diseases (STD) among MSM. For example, among the cases of syphilis, reoccurring locally at super-high levels (160/100,000 MSM, compared to a U.S. rate of 4/100,000) over recent years 1998-2000, 75% say they also have HIV infection (yielding astounding rates of 1,000/100,000 among MSM with HIV).²⁵ These facts suggest the possibility of new HIV spread to any HIV-negative partners of these MSM, especially since STD in general and syphilis in particular greatly enhance the ability of HIV to spread.²⁶



(c) “What populations are closest to the margins of the fire?”

Population groups “closest to the margins of the fire” (and perhaps unaware that they are already on fire, see diagram above) include:

- Persons with HIV who have yet to be tested and to learn their HIV infection status.
- The sex & needle-sharing partners of persons with HIV.
- MSM-IDU, non-injecting MSM, and IDU not yet know to be infected, because they are most likely to be in or develop sexual or drug social networks with HIV-infected persons.
- Persons moving into these groups (e.g., young, newly aware men who find themselves attracted to men, new MSM moving to Seattle, or new IDU.)

As noted above, the proportion of persons with HIV who are neither MSM nor IDU is gradually growing and while their numbers are still relatively small, they are less likely to know their HIV status, therefore less likely to prevent transmitting HIV to partners, and an increasing source of new HIV infections.

A standard public health intervention specifically designed for and intended to address the “margins of fire” (by reaching out to the partners of HIV-infected persons) is called *Partner Counseling & Referral Services (PCRS)*. (PCRS is a new name for “Partner Notification”, formerly also called “Contact Tracing.”) PCRS is important to public health and it works – in all but the population of MSM – to bring to treatment and reduce the risk of further disease spread by persons who may have acquired communicable diseases. In several studies of PCRS for HIV from 20-40% of exposed persons who can be identified and reached are found to have HIV themselves, and typically 50% of those persons have been unaware of their infection. In the MSM population, for reasons that include the anonymity of many partners, PCRS has rarely yielded new cases of HIV infected persons, or of syphilis in the outbreak occurring over the past several years.

Question 2: Which high-risk populations (if any) have been most neglected in terms of prevention efforts, and to what end?

Several groups of persons at high risk for HIV have been noted by Public Health as needing additional attention to heighten the effectiveness of prevention efforts. (We would not really consider most of these groups “neglected”). We interpret that the Council’s phrase “to what end?” asks us to describe the consequences of insufficient prevention efforts targeting these populations.

1. **HIV-infected persons (HIV+).** As noted, these people are 100% HIV-infected and are the sources of all HIV infection spread. (Although this spread is rarely intentional, some spread may result from carelessness by HIV-infected persons). Most HIV spread from persons with HIV probably occurs from the 25-33% of persons whom the CDC estimates have yet to become aware of their HIV-positive serostatus, or from people with HIV (and to partners) who are not routinely taking effective precautions against transmission. Although multiple studies²⁷ show that on average persons who learn they are HIV-infected substantially reduce their risk of transmitting infection to others, local data²⁸ show that HIV+ (MSM at least) continue to report higher levels of risk behavior than HIV-uninfected persons. HIV prevention interventions are needed to target both parts of this group: those who are unaware that they carry HIV and those who already know. The CDC’s 5-year plan (drafted in 2000) has recommended increasing emphasis on both groups.

In Seattle, before 2000 two interventions have been funded specifically to target persons aware of their HIV infection, both of these are projects of the UW School of Social Work, have attracted small numbers of subjects, and have had to resort to indirect strategies to promote HIV prevention to targeted MSM. Beginning in 2000, thanks to extra State HIV Prevention resources, Public Health has contracted with two agencies to begin offering prevention case management (PCM) to persons who are still at high risk and wanting such prevention assistance. Finally, in targeting MSM who use amphetamines, many of whom are HIV-infected, another program has provided prevention services for this population.

The consequences of neglecting sufficient prevention targeting HIV-infected persons are that: 1) HIV-infected persons who remain unaware of their infection continue high level risk behaviors which could spread infection and put themselves at risk of progressive HIV infection and (potentially) complications, including an early and needless death, from untreated HIV or AIDS; and 2) some persons aware of having HIV may continue to behave in ways which could spread HIV which might otherwise be reduced.

2. **Several subgroups of men who have sex with men are deemed to need additional efforts:**
 - **Substance-Using MSM (SU-MSM).** Drug use in association with sex among MSM is highly prevalent, including use of alcohol and marijuana which may cloud judgement about risk-taking. Two drugs have repeatedly been associated with high risk for HIV transmission in the sexual context: poppers and (crystal)

methamphetamine. While there are specific (although probably inadequate) HIV risk-reduction programs for MSM who are also IDU, many of whom use methamphetamine, it is believed that programs for MSM who use high risk drugs around sex are inadequate.

Inadequate prevention targeting SU-MSM would likely result in continued spread of HIV among these SU-MSM, the spread of STD which heighten HIV transmission, the possibility of co-infections with multiple strains of HIV, poor adherence to anti-retroviral drugs fostering HIV resistance and treatment failure among those with infection, and the adverse outcomes of AIDS.

- **African-American MSM (AA-MSM).** This group within the MSM behavioral risk category probably has higher rates of HIV infection than other racial/ethnic groups of MSM but has been targeted by relatively few resources and by programs, which have been cited as intermittently weak by local African-American MSM involved in prevention efforts. Barriers in building and maintaining effective programs for this population have included a high turnover of local AA-MSM leaders, instability in key local agencies, difficulties that AA religious institutions have addressing AA-MSM, and strong denial among AA leadership generally that MSM behavior exists to any meaningful extent. In addition, the small size of this population locally interferes with the success of community organizing efforts.

Inadequate prevention targeting AA-MSM would likely result in uncontained spread of HIV from these MSM to their sex partners. We are not aware of local data documenting lower levels of HIV knowledge and risk reduction skills and higher levels of HIV risk behavior among AA-MSM than among MSM in general.

- **Latino MSM.** This group may also have higher rates of HIV infection than white MSM but has also been targeted by relatively paltry resources and programs. Barriers in building and maintaining effective programs for this population have also included substantial changes and instability in key local agencies, frequent language barriers, lower levels of HIV prevention knowledge in these populations,²⁹ and cultural influences such as *machismo*, *familismo*, and homophobia.³⁰ In addition, as with African-American MSM, the small size of this population locally also makes community organizing efforts difficult.

Neglecting sufficient prevention targeting Latino-MSM would likely result in continued spread of HIV from these MSM to their sex partners.

3. **Native Americans/Alaskan Natives (NA).** Many studies have shown that NA are vulnerable to substance abuse and the transmission of communicable diseases. Although HIV and AIDS epidemiologic data in NA have not demonstrated the rates of HIV disease as high as in AA and Hispanic peoples, there is substantial underreporting in this population (as shown in a local study³¹) since many NA get mis-classified as whites, and do not use NA specific care facilities. Barriers to providing effective HIV prevention include: a high prevalence of substance abuse; the wide distribution of NA people not limited by county, state, or national boundaries; and other specific cultural and behavioral

factors. Finally, they are truly many different nations of people, each requiring highly culturally specific programs.

The consequences of neglecting sufficient prevention targeting NA are likely to be unfettered spread of HIV among NA.

While some other population groups perceive that they have been overlooked and not provided enough prevention attention, public health believes that these groups have not truly been shown to be at high risk, based on a lack of evidence of high rates of HIV/AIDS, STD, or other indicators of risk.

Question 3: How could resources be optimally deployed? (i.e., concentrate dollars upon few “critical” populations or disperse resources more thinly across multiple populations? Fund multiple interventions, or focus on relatively few interventions per target population?) What are the pros and cons of each approach?

1. Target resources for HIV prevention only on populations where the HIV seroprevalence is at least 1% (see first question, above). Within these target groups:

- Target resources only on sub-groups known to be at highest risk of transmitting or acquiring HIV listed in the following priorities (based on HIV seroprevalence and potential for finding new cases who are unaware of their infection):
 1. HIV+s generally,
 2. sex partners of HIV+s,
 3. MSM-IDU,
 4. non-IDU MSM,
 5. non-MSM IDU
- For any of these target populations, fund only a few programs that are designed so as to be complementary and which will result in interventions impacting multiple levels, so that the resources will be likely to have a substantial impact in dose and over time.

2. Insist that funded agencies collaborate and link, to create interventions with similar risk reduction messages to increase doses of key messages delivered to target groups.

3. Insist that funded agencies obtain & promulgate the strong endorsement of key opinion leaders about key messages around risk reduction messages such as: the need for regular HIV counseling & testing among persons who engage in highest risk behaviors, routine STD screening in such populations, HIV disclosure both by HIV-seropositive persons and those at-risk, reducing drug use especially in and around sex, and strengthening the emotional health of targeted communities.

We believe that the pros and cons of these recommendations are addressed in the basic principles section of this document (above) and in our answers to earlier questions.

Question 4: How is the local epidemic similar to the epidemic elsewhere, and how is it dissimilar? (to guide the group in assessing the validity of anecdotal comments raised by particular population advocates based upon national media and studies from elsewhere in the US).

The HIV/AIDS epidemics in Seattle & King County differ in some important ways from what is being seen and reported in other parts of the nation (e.g., the Northeastern states, the Southeastern states), and in the nation as a whole:

Locally in Seattle & King County:

- Over three-quarters of cumulative AIDS cases have been in MSM.
- Most new infections are occurring in MSM.
- Most new infections are occurring in whites, although population-based rates show higher levels of HIV/AIDS in African-Americans, Hispanics, and Native-Americans, and lower rates in Asians/Pacific Islanders.
- Most new infections are occurring in Seattle.
- Most new infections are occurring in men.
- AIDS is no longer the leading cause of death for men 25-44.

Both nationally and locally:

- The proportions of cases of HIV and AIDS are steadily rising among women. In King County, although the proportion of cases in women is rising, AIDS case numbers in women have fallen since 1995 (although they may have leveled in 2000, but we can't tell yet, as reporting is incomplete). Nationally, AIDS cases in women fell between 1997 and 1998, and 1999 cases are estimated to be about the same as 1998 after adjustment for reporting delay.
- Most new infections in men of color can be attributed to MSM risk behavior.
- HIV and AIDS are gradually spreading into people living in suburban and rural communities.

The total number of persons living with AIDS has increased each year since 1993.

Nationally:

- Most reported HIV infections (68% of 21,564 HIV cases reported between 7/99-6/00) and about 70% of reported AIDS cases are in persons of color. Nationally in 1999, an estimated 12,817 AIDS cases were in whites and 29,750 cases in people of color, after adjusting for reporting delay.
- AIDS is no longer the leading cause of death for men 25-44.

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2000 KAB Findings (with selected trends from 1995, 1998)

General HIV/AIDS Knowledge and Beliefs (Tables 1 & 8)

- 40% indicated knowing “a lot” about HIV/AIDS, 48% “some”, 11% “a little”. Single adults and those attending an HIV/AIDS presentation are more likely to indicate knowing “a lot”.
- 70% indicated “no” when asked “Are there drugs available that can prevent AIDS in a person with HIV?” 20% indicated “don’t know”.
- 47% correctly indicated that there are drugs available so that pregnant mothers don’t pass HIV to their infants (37% indicated not knowing). King County residents are more likely than other Western WA, and those attending HIV/AIDS presentation are more likely to answer correctly.
- 80% claimed condoms were highly (34%) or medium (46%) effective in preventing HIV. King County residents are more likely than other West and East, and males are more likely than females to say condoms are highly effective.
- Each year about 40% attended at least one HIV/AIDS education presentation. Younger people, those college educated, and those having known a person with AIDS (PWA) are more likely to have attended.
- 48% indicated having known a PWA. Those attending college are more likely to have know a PWA.

HIV/AIDS-related Attitudes and Policy Preferences (Tables 2 & 9)

- 76% indicate that public funds should pay for drugs to prevent AIDS for people who cannot afford them. Eastern Washington residents and those with higher incomes are less likely to support this. Those having attended an HIV/AIDS presentation and those having known a PWA are more likely to support this.
- 72% believe that health care workers infected with HIV should be required to notify their patients that they are infected. King County residents are less likely than residents from other Western and Eastern counties to agree with this.
- 32% support requiring persons with HIV to report HIV status to their employer (down from 37% in 1998 KAB). Persons outside King County are more likely to support this requirement than are King County residents. Those with higher incomes, and those having known a PWA are less likely to support this requirement.
- 88% think that persons with HIV/AIDS should be required to report the names of partners so that they may be notified. Females are more supportive of this than males; residents of other West counties are more likely to support this than King County residents. Persons with higher incomes, and those having known a PWA are less likely to support this requirement.
- 62% felt that HIV infected persons who continue to expose partners should be quarantined (down from 72% in 1995 KAB). Persons having known a PWA are less likely to support this.

Support for HIV/AIDS-related Education Programs (Tables 3 & 10)

- 90% support education programs for junior and senior high school students about sex, STDs, and HIV/AIDS. 72% support similar education programs on homosexuality.
- 66% support programs making condoms available in high schools through school nurses or health clinics. Residents of King County, younger persons, and those having known a PWA are more likely to support such programs.
- 60% claimed that condom ads should be broadcast over TV or radio. Residents of King County, younger persons, and those having known a PWA are more likely to support such advertising.

Support for Injection Drug Use Prevention Programs (Tables 4 & 11)

- 61% support programs to provide for needle exchanges. King County residents, those that are college educated, and those having known a PWA are more likely to support needle exchange programs.
- 38% support making needles and syringes legal to sell to injection drug users (IDUs). King County residents, those that are college educated, and those having known a PWA are more likely to support making this legal.
- 60% support education programs that would teach IDUs to clean their needles with bleach (up from 55% in 1995 KAB). Those having known a PWA are more likely to support such programs.
- 63% support increasing the availability of methadone treatment programs (up from 54% in 1995 KAB), 19% indicated, “don’t know”. Those attending an HIV/AIDS presentation are more likely to support this.

Self-reported Risk for HIV (Tables 5, 6 & 12)

- 58% indicate having no chance of contracting HIV, 35% report low chances, 6% report medium or high chances. Those with lower incomes are more likely to indicate having medium or high chances.
- 6% confirmed having a defined HIV risk factor. Older persons and Eastern WA residents are less likely to report having a risk factor. 38% of those indicating a risk factor claimed they have no chance to contract HIV.
- 26% of singles ages 18-65 reported having more than one sex partner in the previous 12 months. Of singles having sex in previous 12 months, 37% used a condom during last intercourse. 50% of singles indicating more than one sex partner also indicated using a condom during last intercourse.
- Females are less likely than males to report more than one sex partner in last 12 months. King County residents are more likely than other West WA residents, and younger persons are more likely to have used a condom during last intercourse.
- Of singles ages 18-64 indicating more than one sex partner in last 12 months, 34% reported having no chance of contracting HIV; of singles that reported not using a condom during last intercourse, 43% also reported having no chance of contracting HIV.
- Of singles indicating condoms as highly effective in preventing HIV, 48% reported using condoms during last intercourse. Of singles indicating condoms as medium, low, or not at all effective, 29% reported using a condom during last intercourse.

HIV Testing and Counseling (Tables 6, 7 & 13)

- 41% had been HIV tested since 1990. Males, younger persons, persons having known a PWA, and those having attended an HIV/AIDS presentation are more likely to have been tested. Only 50% of those perceiving themselves at medium or high risk for HIV were tested. Of singles reporting more than one sex partner in previous 12 months, 55% were tested. Of singles indicating not using a condom during last intercourse, 65% were tested.
- 38% of those tested since 1990 reported it was “just to find out if they were infected” 26% were tested as part of a routine check-up, and 21% because of a hospitalization or surgery. 27% indicated that their last test was required (down from 34% in 1995 KAB).
- 92% of those tested reported getting the results of their last test (up from 83% in 1995 KAB). 27% of those tested stated they received counseling with their last test. Those with higher incomes, and older persons are less likely to report getting counseling.
- When combining the 1995, 1998, and 2000 KAB results: Of pregnant women last pregnant and receiving prenatal care in years 1990-1994 (n=130), 45% recalled their health care provider discussing HIV/AIDS with them, 53% recalled being offered an HIV test (68% of those offered the test were tested); Of pregnant women last pregnant and receiving prenatal care in years 1995-2000 (n=175), 56% recalled their health care provider discussing HIV/AIDS with them, 71% recalled being offered an HIV test (80% of those offered the test were tested).



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Community Summit - December 2000

Addressing HIV and STD in Gay and Bisexual Men

Executive Summary

Background

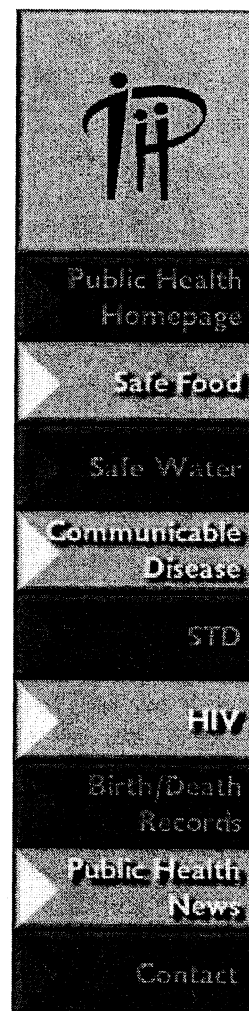
HIV/AIDS has claimed 3,543 lives in Seattle and King County since 1982. Today, an estimated 6,000 persons are living with HIV/AIDS, a number that has been increasing each year since the start of the epidemic.

The emergence of the HIV/AIDS epidemic among gay and bisexual men (GBM) in the early 1980s was preceded in the 1970s by a dramatic increase in rates of traditional sexually transmitted diseases, such as gonorrhea and syphilis. In 1982, for example, the incidence of gonorrhea in King County was at least 1,800 cases per 100,000 GBM, and the rate of syphilis approximated 150 per 100,000. As GBM became aware of the gravity of HIV/AIDS and prevention strategies became more abundant and effective, risk behaviors dropped sharply. As a result, STD rates dropped significantly as well. By 1996, infectious syphilis had been completely eliminated among all populations in King County, and the annual rate of gonorrhea in GBM had declined to under 200 cases per 100,000.

Current issue

Since 1997, sexually transmitted diseases (STDs) and risky sexual behaviors have been on the rise among gay and bisexual men. Syphilis re-emerged in 1997 and is once again epidemic in King County GBM; in 1999 and 2000 the estimated incidence of syphilis among GBM was back up to the 1982 level of 150 per 100,000. Moreover, most GBM with syphilis now are also infected with HIV.

The rates of gonorrhea and chlamydial infection also have increased dramatically; in 1999 and 2000 there were an estimated 400 gonorrhea cases per 100,000 GBM, and the frequency of chlamydia among GBM attending the Public Health STD Clinic has tripled. Local collaborative research by the University of Washington and Public Health -Seattle & King County has documented high and likely rising rates of unsafe sex among GBM. Similar trends are being observed in several North American and western European cities. In terms of HIV, preliminary data suggest that the rate of new HIV infections in GBM also is rising in King County. HIV prevalence in GBM attending Public Health - Seattle & King County's STD clinic



rose steadily from 1997-1999. Such rises have been solidly documented elsewhere (e.g., San Francisco).

Contributing factors

A number of factors are believed to have contributed to this resurgence of disease, including:

- **Improved HIV therapy:** Effective new HIV treatments, unveiled in 1996, have led some GBM to perceive HIV as a manageable, even curable, disease. The perceived importance of maintaining safer sexual behaviors has waned, as has the fear of AIDS. This effect probably is both direct ("AIDS is cured") and indirect (healthier persons are more sexual than sick ones).
- **"Epidemic fatigue" and "safer sex burnout":** After coping with the HIV/AIDS epidemic for 20 years, some GBM may have lost the will or energy to maintain safer sex. The previous norm of universal condom use is outmoded in some segments of the GBM community, and healthy behavioral norms have not yet emerged.
- **Substance use:** Drug use, especially rising abuse of crystal methamphetamine and continuing use of inhaled nitrites ("poppers"), appears to be directly related to unprotected sex with multiple, anonymous partners and to the syphilis epidemic among GBM.

Community-based response

The resurgence of STDs and HIV in this community is unacceptable. Seattle and King County have long been places where Public Health-Seattle & King County and affected communities have partnered to develop the most effective prevention programs possible. Twenty years into the HIV/AIDS epidemic, it is clear that Public Health - Seattle & King County and the GBM communities must redouble and revitalize efforts to prevent further spread of the disease. It is firmly believed that community-driven solutions will have the greatest impact in addressing this issue.

With this approach in mind, a joint Public Health and community summit for Seattle and King County was held on World AIDS Day, December 1, 2000. The stated summit goals were:

- Community-based organizations serving the GBM population will commit to *revitalizing their efforts* to fight the STD/HIV epidemics, and will *create agendas* designed to address these epidemics.
- Summit participants will provide input to assist Public Health - Seattle & King County in using public health resources in the most effective way possible.

Sixty individuals attended, representing a broad range of community based organizations and institutions, and local, state

and federal public health staff.

After listening to presentations on the most current STD and HIV data and hearing community perspectives on the epidemic, the participants worked intensively in small groups to generate feasible action steps and agendas to employ within community-based organizations and Public Health- Seattle & King County. These recommendations were shared with all participants at the close of the summit.

Recommendations

Recommendations from the Summit generally fell into three categories:

- Investigate the need for improvements in *clinic services*. Pilot new case finding partner management and clinical service models to address service access barriers, develop and disseminate screening guidelines to providers and perform formative evaluations.
- Increase *coalition building* to create better prevention efforts, and to include mental health, substance use treatment and other community systems; and immediately establish a diverse coalition of agencies serving men who have sex with men to focus on the issues and action steps described in this report.
- Develop *community-driven prevention messages*. Public Health and community organizations and leadership should jointly develop new prevention messages to help mold current community norms and values.

Definition

In this document, we will consistently refer to men who have sex with men as "gay and bisexual men" (GBM), but we acknowledge and respect the great diversity among men who have sex with men. Some identify as gay, some bisexual, some transgendered, some heterosexual. For some men, their primary identification is with an ethnic or racial group, rather than with the gay, bisexual or transgendered community. All programs serving GBM must be cognizant of these differences, and plan programs accordingly.

This report will be widely disseminated, and Public Health - Seattle & King County will work with its community partners in monitoring implementation of these new agendas as well as following data trends. It is the belief of Public Health - Seattle & King County that the conviction and spirit with which the GBM community fought the HIV epidemic in the 1980's can be recaptured and strengthened within the context of a broadly healthy community.

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The Seattle Area Young Men's Survey: Results from Phase 1

The Seattle-King County Department of Public Health recently completed Phase 1 of the Young Men's Survey (YMS). The purpose of YMS is to gain a better understanding of the prevalence of HIV and hepatitis B, sexual and drug-use behaviors, and related psychosocial factors among young men who have sex with men (MSM) and use these findings to evaluate and improve local HIV prevention efforts. Phase 1 includes 15-22 year old MSM and Phase 2 includes those 23-29. YMS is funded by the Centers for Disease Control and Prevention (CDC). Phase 1 has been conducted in the San Francisco Bay Area, Los Angeles, Dallas, Miami, Baltimore, and most recently in New York City and the Seattle area. Most other surveys of young MSM have used non-probability sampling techniques and their results have not been generalizable to broader populations of young MSM.

Results from the San Francisco Bay Area YMS published in 1994¹ gained wide attention because of the high prevalence of HIV (9.4%) and risky sexual behaviors observed. In the Seattle-King County area, more than three-quarters of all AIDS cases continue to occur in MSM and there is great concern about the risk and spread of HIV and other sexually transmitted diseases among young MSM. However, prior to this survey, there was little local information available to guide education and prevention planning and evaluation efforts for this important target population. This report presents an overview of results from the Seattle Area Phase 1 YMS. Future reports will include results from more focused analyses of specific topics.

Methods

The Young Men's Survey is an anonymous cross-sectional probability sampling survey that uses multi-stage sampling methods to recruit young men at venues in the community that are frequented by young MSM.² Sampling venues are identified through a community assessment process and include street locations, bars, dance clubs, parks, beaches, and other locations or events that are popular with young MSM. Those venues that yield 7 or more eligible persons in a 4-hour period are included in a sampling frame from which 12-14 venues are randomly chosen every month to construct a sampling calendar. During Phase 1 sampling events YMS interviewers approached potential participants and asked them about their age and

county of residence to determine eligibility. Those who were between 15 and 22 years old and resided in King County were invited to participate in the study.

The Seattle-King County YMS project used a 29 foot long recreational vehicle as a field office. After obtaining informed consent from the participant, the interviewer administered a standardized questionnaire that included questions on sociodemographics and sexual and drug-use behaviors, psychosocial factors, and health history. Following the interview, counseling for HIV, hepatitis B and other sexually transmitted diseases was conducted and a blood sample drawn. Referrals to health or social service agencies were provided as needed and all participants received condoms and a monetary incentive. A post-test counseling appointment was also scheduled. Hepatitis C serology was added to the testing regimen several months after the start of the survey. Stored sera from early participants were also tested for antibodies to hepatitis C and all stored sera were tested for antibodies to hepatitis A.

Results

Between October 1997 and October 1998, the YMS team conducted 211 sampling events at 33 venues and intercepted 4,395 men of whom 851 were eligible for the study. A total of 528 (62%) agreed to participate and 377 (71%) were MSM. Nine were determined to be duplicate participants and thus the final MSM sample available for this analysis was 368.

Sociodemographic characteristics: Of the 368 MSM participants, 111 (30%) were 15-18 years old and 257 (70%) were 19-22 years old (Table 1). Ninety-five percent identified as gay or bisexual. Slightly less than two-thirds were White, 8% were African Americans, 15% identified as another race/ethnicity (Hispanic, Asian/Pacific Islander or Native American) and 13% as mixed race. Almost half of the younger group was born in the Seattle area compared to less than a quarter of the older group and 38% of the older group moved to the area after they turned 19. Forty-eight percent of the younger group lived with their parents whereas 51% of the 19-22 year olds lived with a friend or a roommate. Three-quarters of the younger sample were still in school and 46% worked full or part-time. Among the older sample, 36% were in school and 80% worked full or part-time. Over one-third of the participants reported having run away from home at some point in their life.

Sexual behavior: Everybody reported sex with another man at some point in their life with 76% of the 15-18 year olds reporting anal sex with another man compared to 82% of the 19-22 year olds (Table 2). The number of sex partners was significantly higher among the older group with 72% reporting 5 or more in their lifetime and 28% reporting 5 or more in the past 6 months compared to 45% and 13%, respectively, of the younger men.

Over half also reported sex with a female.

The older group was significantly more likely to report a steady male sex partner (someone they had sex with three or more times) in the past 6 months than the younger age group (68% versus 48%). Two-thirds also reported a non-steady partner (pick-up, one-night stand or casual partner with whom they only had sex once or twice) and 7% reported an "exchange partner" (someone the respondent had sex with in exchange for things respondent needed or the partner needed). Twenty percent reported sex with a female partner in the 6 months prior to the interview.

Among those who reported anal sex with another man in the past 6 months, 43% said they always used a condom with any male partner. Condom use was lower during receptive anal sex with a steady partner (43%) compared to receptive anal sex with a non-steady partner (56%) and did not vary significantly by age group.

Drug and alcohol use behaviors: Virtually all participants reported drinking alcohol (Table 3). Drug use was also very prevalent in the study population and generally higher among the older group. Many participants had tried a variety of different drugs, but fewer reported using in the past 6 months. Marijuana use in the past 6 months was reported by almost two-thirds. Other common drugs reported in the past 6 months included amphetamines/speed (28%), LSD/hallucinogens (26%), ecstasy (20%), cocaine (19%), poppers/nitrates (13% of the 15-18 year olds and 21% of the 19-22 year olds), and barbiturates/downers (12%).

Thirteen percent reported ever injecting drugs, while 5% reported injecting in the past 6 months. The most commonly injected drugs were amphetamine which was reported by 71% of those who had injected, followed by heroin (47%), cocaine (37%), and speedball (27%) (data not shown). Only 4% reported injection of steroids and none reported injecting other hormones.

Health history: YMS participants reported seeking health care at a variety of different locations (Table 4) with private physician (46% of 15-18 year olds and 26% of 19-22 year olds) being the most common source of health care followed by health maintenance organizations (22%), and community clinics (18%). Seventeen percent of the older group reported having been diagnosed with a sexually transmitted disease compared to 5% of the younger group. Thirty-six percent said they had completed the hepatitis B vaccination series and 10% recalled having had part of the series. The most common reason for missing hepatitis B vaccination was lack of knowledge which was reported by 45% of those who said they had not been vaccinated; 16% considered themselves to be at low risk and only 8% cited expense as a reason (data not shown). Three-quarters of the older group had previously been tested for HIV compared to 59% of the younger group.

Prevalence of infections: Prevalence of infections was somewhat higher among the older group. A total of 8 (2%) tested positive for antibodies to HIV, five knew about their HIV infection and three were newly diagnosed. All but one of the infections were among the 19-22 year olds.

Five percent showed markers of infection with hepatitis B (anti-HBc+), but only 1% had chronic hepatitis B infection (HBsAg+). Thirty-nine percent of 15-18 year olds and 30% of the 19-22 year olds had markers of immunity to hepatitis B infection (anti-HBs+). Among those with surface antibodies and no core antibodies, 73% reported a completed 3-shot series of hepatitis B vaccination and 13% reported a partial series. Among those who reported a full vaccination series, 64% were anti-HBs positive and among those who reported partial vaccination 40% were anti-HBs positive. A significantly higher proportion of 19-22 year olds had seromarkers of past hepatitis A infection compared to the 15-18 year olds (15% versus 4%). Five respondents were positive for antibodies to hepatitis C and four of those reported injection drug use.

Comments

We found a high prevalence of risky sexual behaviors and drug use among Seattle Area YMS participants, similar to findings from other YMS sites.³ The high prevalence of sex with both non-steady and steady partners along with the inconsistent use of condoms for receptive anal intercourse in the 6 months prior to the interview is worrisome. An article by Garofalo et al⁴ found that gay, lesbian and bisexual high school students reported riskier sex behaviors than heterosexual students, including younger age at first sexual intercourse and higher number of lifetime and recent sexual partners.

Drug use among the 15-18 year old YMS participants was much higher than drug use reported by Seattle high school students in the 1995 Teen Health Risk Survey.⁵ Forty-eight percent of students reported ever using marijuana compared to 69% of the 15-18 year old YMS participants. Lifetime use of hallucinogens was 15% among high school students compared to 43% in 15-18 year old YMS and 8% of high school students reported ever trying stimulants compared to 35% of YMS participants. The Garofalo study also reported higher drug and alcohol use among gay, lesbian and bisexual high school students compared to heterosexual high school students.⁴ An abstract presented by CDC at the 12th World AIDS Conference in Geneva⁶ reported that predictors of unprotected receptive anal intercourse in YMS participants included being high on alcohol or amphetamines during sex and recommended targeting alcohol and amphetamine use in addition to promoting safer sex to help prevent HIV transmission.

The Seattle YMS had the lowest HIV prevalence of all YMS sites, 2% compared to a range of 4% to 8% at other sites.³ By

age, prevalence was 2% and 3%, respectively among 15-19 year and 20-22 year old Seattle Area participants compared to a range of 3%-6% and 4%-10%, respectively, among these two age groups at other sites. HIV prevalence was 3% among both Whites and Blacks in the Seattle Area compared to 2%-5% and 8%-13% among Whites and Blacks, respectively, at other sites.

The Seattle area had the highest hepatitis B immunization rates among all the YMS sites.⁷ However, considering that hepatitis B vaccination has been recommended for MSM since 1982 and that the vast majority of participants reported contact with the health care system, vaccination rates in our area are disappointingly low. A recently funded hepatitis A and B education project for Seattle MSM may help address this need. The discrepancy between reported vaccination history and anti-HBs status is most likely due to problems with correct recall or waning antibodies.

A recent article from the San Francisco Bay Area YMS compared HIV prevalence and risky sexual and drug-use behaviors among 17-22 year old YMS participants from two different surveys conducted in 1992-93 and 1994-95.⁸ Despite increased attention to prevention efforts among young MSM in San Francisco before the second survey, no differences in HIV prevalence or risky behaviors were noted. The authors concluded that "implementation of effective prevention interventions among young MSM are needed as badly as they were 3 years ago."

Although HIV prevalence was relatively low in our area, risky sexual behaviors and drug use were common. Clearly, education and prevention efforts focusing on safer sex practices, reduction of drug and alcohol use and improvement of hepatitis B vaccination rates continue to remain important needs among young MSM in the Seattle area.

Please contact Hanne Thiede (hanne.thiede@metrokc.gov or (206) 296-7879) or Tom Perdue, YMS Coordinator (tom.perdue@metrokc.gov or (206) 205-7357) if you have questions about the Young Men's Survey.

Contributed by Hanne Thiede DVM, MPH, Tom Perdue, and the YMS Team (Stanley Brown, Allan Carandang, Leonard Dawson, Jan Fields, Patrick Gonzalez, Justin Haines, David Miller, Jason Naki, Misha Williams, and Robert Yoon)

We would like to thank all the participants, the collaborating venues, the Community Advisory Board, the SKCDPH Laboratory and the CDC YMS staff who helped make the Seattle YMS a success. In addition, we appreciate the assistance of Dr. Lawrence Corey, Dr. Catherine Diamond, and the staff of Children's Medical and Regional

*Centers'
Virology Laboratory in performing hepatitis A and C testing.*

Table 1. Sociodemographic characteristics of Seattle-King County YMS participants

Characteristics	15-18 years N=111	19-22 years N=257	Total N=368
Sexual identity¹			
Gay	68%	77%	74%
Bisexual	26%	18%	21%
Heterosexual	6%	5%	5%
Race*			
White	59%	67%	64%
Black	14%	5%	8%
Other	10%	16%	15%
Mixed	17%	12%	13%
Age moved to King County*			
Born and raised here	45%	23%	30%
<15 years	25%	14%	17%
15-18 years	30%	26%	27%
20-22 years	NA	38%	26%
Living status*			

Alone in house/apartment	5%	14%	11%
With parents/guardians	48%	15%	25%
With other relatives	6%	3%	4%
With friend(s)/roommate(s)	20%	51%	42%
With sexual partner/lover	2%	8%	6%
In school dormitory	9%	4%	6%
Homeless (shelter/group home/other)	6%	4%	5%
Other	4%	1%	2%
Currently in school*			
Yes	76%	36%	48%
Working status*			
Full-time	12%	55%	42%
Part-time	34%	25%	28%
Unemployed – seeking work	35%	12%	19%
Unemployed – not seeking work	19%	8%	11%

Ever run away from home			
Yes	38%	37%	37%

Based on a scale of 1 to 7: 1=exclusively straight and 7=exclusively gay; 1 and 2 defined as straight, 3, 4 and 5 defined as bisexual and 6 and 7 as gay

*Indicates a statistical significant difference ($p < 0.05$) between the 15-18 year old and the 19-22 year old age groups

Table 2. Sexual behaviors among Seattle-King County YMS participants

	15-18 years	19-22 years	Total
Sexual behaviors	N=111	N=257	N=368
Type of sex with another male			
Oral sex ever	98%	100%	99%
Anal sex ever	76%	82%	80%
Anal sex past 6 months	59%	70%	67%
Age at first anal sex with another male*			
<14 years	14%	6%	8%
14-16 years	38%	19%	25%
17-18 years	24%	31%	29%
19-22 years	0	26%	18%
No anal sex with men	24%	18%	20%
Number of male sex partners ever (oral or anal sex)*			

1 partner	19%	8%	11%
2-4 partners	36%	19%	24%
5+ partners	45%	72%	64%
Sex with a female ever			
Yes	52%	56%	55%
Number of male sex partners in past 6 mo (oral or anal)*			
0 partners	16%	12%	13%
1 partner	30%	19%	22%
2-4 partners	41%	41%	41%
5+ partners	13%	28%	23%
Type of sex partners in past 6 months (oral or anal)			
Male steady partner^{1*}	48%	68%	62%
Male non-steady partner²	64%	63%	64%
Male exchange partner³	9%	7%	7%
Female partner	25%	18%	20%
Injection drug using partner (ever injected drugs)	12%	12%	12%
Condom use during anal sex in past 6 months among those who reported these			

those who reported these partners			
Always during anal sex with any male	47%	36%	43% (N=245)
Always during receptive anal intercourse w/steady male partner	42%	43%	43% (N=152)
Always during receptive anal intercourse w/non-steady partner	55%	57%	56% (N=112)

*Indicates a statistical significant difference ($p < 0.05$) between the 15-18 year old and the 19-22 year old age groups

1Regular partners whom respondent had sex with three or more times

2Pick-ups, one-night stands or casual partners respondent had sex with only one or two times

3Partners respondent had sex with in exchange for things respondent needed or sex partner needed

Table 3. Drug use behaviors among Seattle-King YMS participants

Behaviors	15-18 years N=111	19-22 years N=257	Total N=368
Alcohol use			
Ever	92%	97%	95%
Last 6 months*	86%	95%	92%
High during sex last 6 months*	30%	55%	48%
Marijuana/Hash			
Ever*	69%	80%	77%
Last 6 months	57%	64%	62%
High during sex last 6 months	25%	31%	29%
Uppers/Speed/Amphetamines			
Ever*	35%	48%	44%
Last 6 months	26%	29%	28%
High during sex last 6 months*	6%	16%	13%

Downers/Barbiturates			
Ever	17%	23%	21%
Last 6 months	10%	13%	12%
High during sex last 6 months	0	3%	2%
Ecstasy/XTC			
Ever*	24%	39%	34%
Last 6 months	17%	21%	20%
High during sex last 6 months	4%	9%	8%
LSD/Hallucinogens			
Ever	43%	52%	49%
Last 6 months	27%	26%	26%
High during sex last 6 months*	0	6%	4%
Poppers/Nitrates			
Ever*	21%	37%	32%
Last 6 months*	13%	21%	19%
High during sex last 6 months*	5%	14%	11%
Cocaine			
Ever*	19%	41%	34%
Last 6 months	14%	21%	19%
High during sex last 6 months*	4%	10%	8%
Crack			
Ever	8%	13%	11%
Last 6 months	2%	5%	4%
High during sex last 6 months	0	1%	1%
Heroin			
Ever	8%	11%	10%
Last 6 months	2%	4%	3%
High during sex last 6 months	0	1%	1%
Ever injected drugs including steroids			
Yes	12%	14%	13%
Injected drugs including steroids past 6 months			

Yes	4%	6%	5%
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* Indicates a statistical significant difference ($p < 0.05$) between the 15-18 year old and the 19-22 year old age groups

Table 4. Health history among Seattle-King County YMS participants

Health history	15-18 years N=111	19-22 years N=257	Total N=368
Any usual source of health care			
Public health department clinic	9%	11%	10%
Community-based clinic	18%	18%	18%
College/school clinic*	2%	11%	8%
Health Maintenance Organization (HMO)	19%	23%	22%
Private MD*	46%	26%	32%
Hospital clinic	11%	12%	12%
Emergency room	9%	11%	10%
Other	9%	8%	8%
Don't seek health care*	2%	8%	6%
Ever had a sexually transmitted disease*			
Yes	5%	17%	13%
Hepatitis B vaccination			
Yes	42%	33%	36%
Incomplete series	13%	9%	10%
No	34%	45%	42%
Don't know	11%	12%	12%
Ever been tested for HIV*			

Ever been tested for HIV*			
Yes	59%	75%	70%
Ever known somebody with HIV			
Yes	71%	79%	77%

*Indicates a statistical significant difference ($p < 0.05$) between the 15-18 year old and the 19-22 year old age groups

¹Among those who responded "No" to hepatitis B vaccination

Table 5. Prevalence of sexually and parenterally transmitted viral infections among Seattle-King County YMS participants

Serology	15-18 years N=111	19-22 years N=257	Total N=368
HIV antibody+	1%	3%	2%
History of hepatitis B infection (anti-HBc+)	5%	6%	5%
Chronic hepatitis B infection (HBsAg+)	0%	1%	1%
Hepatitis B immunity (anti-HBs+)	39%	30%	32%
History of hepatitis A (IgG+)*	4%	15%	11%
Hepatitis C (anti-HCV+)	2%	1%	1%

*Indicates a statistical significant difference ($p < 0.05$) between the 15-18 year old and the 19-22 year old age group

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The Seattle Area Young Men's Survey: Phase 2 results

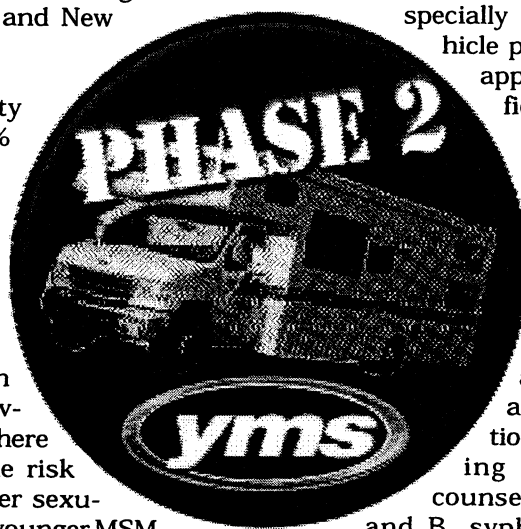
Public Health - Seattle & King County recently completed Phase 2 of the Young Men's Survey (YMS 2). The purpose of this study was to gain a better understanding of the prevalence of HIV and hepatitis A and B, and sexual and drug-use risk behaviors among young men who have sex with men (MSM). YMS Phase 1 (15-22 year old MSM) was conducted between October 1997 and October 1998. Data collection for Phase 2 (22-29 year old MSM) occurred between December 1998 and February 2000. YMS was part of a multi-site Centers for Disease Control and Prevention study that was also conducted in the San Francisco Bay area, Los Angeles, Baltimore, Dallas, Miami, and New York City.

In the Seattle-King County area MSM account for 82% of persons living with AIDS and 75% of persons living with non-AIDS HIV infection. In recent years rates of infection with syphilis, gonorrhea, and chlamydia have increased among King County MSM indicating high levels of risky sexual behaviors among some MSM and there is great concern about the risk and spread of HIV and other sexually transmitted diseases in younger MSM.

Most other surveys of young MSM have used convenience samples and their results cannot be generalized to broader populations of young MSM. Prior to YMS there was little local information available to guide prevention planning and evaluation efforts for young MSM. This report presents an overview of results from the Seattle Area Phase 2 YMS. Results from YMS Phase 1 were reported in earlier issues of this publication (4th Quarter 1998 and 2nd quarter 1999).

ment process and included street locations, bars, dance clubs, parks, beaches, and other locations or events that are popular with younger MSM. Venues that yielded 7 or more eligible persons in a 4-hour period were included in a sampling frame from which 12-14 venues were randomly chosen every month to construct a sampling calendar. During sampling events YMS interviewers approached potential participants and asked them about their age and county of residence to determine eligibility. Those between 23 and 29 years old who resided in King County were invited to participate. Participants could either complete the study at the time of recruitment (inside a specially equipped recreational vehicle parked nearby) or make an appointment at the YMS office on Capitol Hill.

After obtaining informed consent, study interviewers administered a standardized questionnaire that included questions on sociodemographic characteristics, sexual and drug use behaviors, and health care and prevention services history. Following the interview, pre-test counseling for HIV, hepatitis A and B, syphilis and other sexually transmitted diseases (STDs) was conducted and a blood sample was drawn. All participants received a monetary incentive and were offered free condoms and risk-reduction information. A results and post-test counseling appointment was also scheduled. Referrals for hepatitis A and B vaccinations and other health and social services were provided as needed. Stored sera were tested for antibodies to hepatitis C after all data collection was completed.



Methods

The Young Men's Survey was an anonymous cross-sectional probability sampling survey that used multi-stage sampling methods to recruit young men at venues that were frequented by young MSM.¹ Sampling venues were identified through a community assess-

Results

Between December 1998 and February 2000 the YMS team conducted 197 sampling events at 27 different community venues and intercepted 2,843 men of whom 934 (36%) were eligible for the study. A total of 506 (54%) agreed to participate, 92% (468) of whom were

MSM. After exclusion of data from 5 duplicate participants and one participant whose responses were judged to be unreliable, the final sample available for this analysis was 462 MSM.

Sociodemographic characteristics (Table 1): The vast majority (85%) of the participants identified as gay. The median age of the respondents was between 25 and 26. Over three-quarters were White, 9% were Asian or Pacific Islander, 5% were Hispanic, 4% Black, and 1% American Indian or Alaska Native. The majority was employed full-time. Well over half had a college degree and another quarter had some college experience; 13% were currently in school. The median income was between \$20,000 and \$29,000. Most lived with friends or roommates (43%) or alone in a house or apartment (28%); 20% lived with a sex partner.

Sexual behavior (Tables 2, 3 and 4): Ninety-two percent reported ever having had anal sex with another man and 78% (361) reported anal sex with another man in the past 6 months (Table 2). While over half of the participants

reported ever having had sex with a female, only 8% reported sex with a female in the past 6 months. The median number of lifetime male sex partners was 20 and the median for the past 6 months was 2. In the past 6 months, 28% reported one male partner, 36% 2-4 male partners, and 29% 5 or more male partners. When asked about type of male sex partner in the past 6 months, 71% reported at least one new male sex partner, 75% reported at least one steady male sex partner (regular boyfriends or lovers with whom the participant had sex 3 or more times), 59% reported at least one non-steady male sex partner (pick-ups, one-night stands, or casual partners with whom the participant had sex less than 3 times), and 3% reported at least one exchange partner (partners with whom the participant had sex in exchange for things like money, food, or drugs).

The questionnaire asked about condom use during anal sex with other men in the past 6 months and about number and type of sex (anal or oral) partners in the past 6 months, but it did not ask about condom use with individual partners or with specific type of partners. Overall, 49% (224) of all participants

Table 1. Sociodemographic characteristics of Seattle-King Co. YMS 2 participants

Sociodemographic characteristics	Total N=462	Sociodemographic characteristics	Total N=462
Sexual identity		Education	
Gay	85.2	High School/GED or less	11.5
Bisexual	8.3	Technical/vocational	5.6
Heterosexual	2.8	Some college	27.1
Don't know	3.7	College degree	55.8
Age		Currently in school	
23-26 years	58.4	Yes	13.0
27-29 years	41.6	Income	
Race/ethnicity		<\$15,000	15.8
White	76.8	\$15,000-29,999	41.8
Black	3.7	\$30,000-39,999	23.2
Hispanic/Latino	5.4	≥\$40,000	19.3
American Indian/Alaska Native	0.9	Living status	
Asian/Pacific Islander	9.3	Alone in house/apartment	28.4
Other	3.9	With parents/guardians/relatives	7.6
Working status		With friends/roommates	42.9
Full-time	81.8	With sex partner	20.1
Part-time/Occasionally	9.7	Other	1.1
Unemployed	8.4		

reported not always using a condom during anal sex with men in the past 6 months (Table 2). Among the 361 respondents who reported anal sex with a man in the past 6 months, 20% never used a condom, 42% used a condom sometimes and 38% always used a condom (Table 3). Young men with two or more partners were more likely to have used a condom either sometimes (50%) or always (39%) compared to those with only one partner (20% and 34%, respectively). Participants who reported new partners or non-steady partners were also more likely to report condom use than those who did not report these types of partners.

Table 4 shows the different reasons for not always using a condom among those with only one partner in the past 6 months and those with two or more partners in the past 6 months. Ninety-two percent of those with one sex partner said that "being in a mutually-faithful relationship" was the reason they didn't use a condom. Among those with 2 or more male sex partners in the past 6 months, 47% (77) also said the reason was that they were in a mutually-faithful relationship. When further questioned whether their unprotected sex was only with partners with whom they had a mutually-faithful relationship, 58 of 77 (75%) responded yes. Fifty-one of these 77 men reported 2-4 partners and 26 reported 5 or more partners in the past 6 months. Other

common reasons for not always using condoms among those with multiple partners included knowing that they were HIV-negative (56%), knowing that their partners were HIV-negative (47%), knowing that they both had the same HIV status (51%), or believing that their partners were at low risk (52%). Forty-seven percent said that they did not use a condom because "they were in the heat of the moment" and 27% said it was because they were high on drugs or alcohol. About one-third said that either they or their partners did not like using condoms.

Drug and alcohol use (Table 5): Virtually all respondents had used alcohol and 82% had used some form of drugs in their lifetime; 63% had used drugs in the past 6 months. Overall, 71% had been high or buzzed on alcohol (63%) or drugs (39%) during sex in the past 6 months. The most commonly used drug was marijuana (78%) followed by LSD or other hallucinogens (45%), ecstasy (41%), poppers (40%), cocaine or crack (36%), and crystal (32%). In the 6 months prior to the interview 52% had used marijuana, 24% ecstasy, 22% poppers, and 18% crystal. Five percent reported ever having injected drugs and 1% had injected in the past 6 months.

Health history (Table 6): Over two-thirds reported a regular source of health care, with health care maintenance organizations being

Table 2. Sexual behaviors among Seattle-King Co. YMS 2 participants

Sexual behaviors	Total N=462	Sexual behaviors	Total N=462
Anal sex with men		Male sex partners last 6 mos.*	
Ever	92.4	0	7.8
Past 6 months	78.1	1	27.5
Sex with female		2-4	36.1
Ever	57.8	≥5	28.6
Last 6 months	8.0	Type of male sex partner last 6 mos.*	
Male sex partners ever*		New	70.8
1-4	11.9	Steady	74.7
5-9	15.2	Non-steady	59.3
10-19	21.6	Exchange	2.6
≥20	51.3	Condom use last 6 mos.**	
		Not always	48.5

* Includes partners with whom participant had anal or oral sex

** Denominator includes all YMS MSM participants; only 78% reported anal sex with another man in the past 6 months

Table 3. Condom use during anal sex in the past 6 months among Seattle-King Co. YMS participants

Sexual behaviors and partner characteristics	Any condom use in the past 6 months* N=361			
	Total N (col %)	Never N (row %)	Sometimes N (row %)	Always N (row %)
Type of anal sex				
Any anal sex	361 (78.1)	72 (19.9)	152 (42.1)	137 (38.0)
Insertive anal sex	320 (69.3)	63 (19.7)	145 (45.3)	112 (35.0)
Receptive anal sex	296 (64.1)	56 (19.0)	129 (43.9)	110 (37.2)
Number of partners				
1	93 (25.8)	42 (45.2)	19 (20.4)	32 (34.4)
≥2	268 (74.2)	30 (11.2)	133 (49.6)	105 (39.2)
New partner				
0	81 (22.4)	39 (48.2)	18 (22.2)	24 (29.6)
1	61 (16.9)	16 (26.3)	22 (36.1)	23 (37.7)
≥2	219 (60.7)	17 (7.8)	112 (51.1)	90 (41.1)
Non-steady partner				
0	127 (35.2)	46 (36.2)	35 (27.6)	46 (36.2)
≥1	234 (64.8)	26 (11.1)	117 (50.0)	91 (38.9)
Steady partner				
0 - 1	240 (66.5)	64 (26.7)	88 (36.7)	88 (36.7)
≥2	121 (33.5)	8 (6.6)	64 (52.9)	49 (40.5)

* The questionnaire asked about number and type of sex partners and about condom use in the past 6 months, but it did not ask about condom use with specific or individual male partners. Thus condom use refers to any condom use in the 6 months prior to the interview.

Table 4. Reasons why condoms were not always used during anal sex in the past 6 months among Seattle-King Co. YMS participants

Any reasons why condoms were not used during anal sex with male partners in the past 6 months	Didn't always use condoms during anal sex in the past 6 months N=224		
	Total N=224 %	1 partner* N=61 %	≥2 sex partners* N=163 %
Didn't like using condoms	35.7	37.7	35.0
Partner didn't like using condoms	33.5	34.4	33.1
No condom was available**	16.1	6.6	19.6
Didn't worry about using condoms**	46.9	60.7	41.7
Didn't think he could get/transmit HIV	16.5	23.0	14.1
Were in the heat of the moment**	38.4	16.4	46.6
High or buzzed on drugs or alcohol**	21.0	4.9	27.0
Knew he was HIV-negative**	62.1	78.7	55.8
Knew partner was HIV-negative**	53.6	72.1	46.6
Knew he and partner had same HIV status**	58.9	80.3	50.9
Thought partner was at low risk for HIV	52.2	52.5	52.2
Was in mutually faithful relationship**	59.4	91.8	47.2

* The YMS participants included in this table had all had unprotected anal sex with another man in the past 6 months. However, questions regarding number of sex partners do not distinguish between oral and anal sex partners and it is possible that some of the sex partners were oral sex partners only.

**Indicates a statistically significant difference at $p < 0.05$ in reason for not using a condom between those with 1 partner versus those with 2+ partners

the most common source (29%) followed by a physician or group practice (non-HMO) (23%). One-quarter reported having been diagnosed with a sexually transmitted disease at least once in their life. One-third had completed the 3-shot hepatitis B (HBV) vaccination series and 21% had completed hepatitis A (HAV) vaccinations. Among those who had not been vaccinated the most common reasons was not having been informed about the vaccine by their health care provider (45% for HAV and 42% for HBV vaccinations), and lacking knowledge about the vaccine (22% for HAV and 37% for HBV vaccination). Seventeen percent said they were not vaccinated because they were at low risk for HAV and 18% said they were at low risk for HBV. Lack of time was cited as a

reason by 10% of those without HAV vaccination and 8% of those without HBV vaccination. Eight percent said that they had already had HAV or HBV infection. Only about 5% said that cost was an issue. More than 90% had previously been tested for HIV—17% within 3 months, 33% within 6 months, and 58% within a year.

Prevalence of infections (Table 7): A total of 22 (5%) participants were seropositive for HIV and 13 (59%) knew of their positive HIV status. Nineteen percent showed serological markers for prior infection with hepatitis B; less than 2% had chronic hepatitis B infection and 40% were seropositive for surface antibodies indicating immunity as a result of

Table 5. Drug and alcohol use behaviors among Seattle-King Co. YMS 2 participants

Drug and alcohol use behaviors	Total N=462 %	Drug and alcohol use behaviors	Total N=462 %
Alcohol use		Poppers or nitrites	
Ever	98.5	Ever	39.8
Last 6 months	94.8	Last 6 months	22.1
High during sex last 6 months	62.9	High during sex last 6 months	18.6
Any drug use		Crystal	
Ever	82.3	Ever	32.3
Past 6 months	63.4	Last 6 months	18.2
High during sex last 6 months	39.0	High during sex last 6 months	10.6
Marijuana/Hash		Uppers/Speed*	
Ever	77.5	Ever	14.5
Last 6 months	51.9	Last 6 months	2.6
High during sex last 6 months	22.3	High during sex last 6 months	0.6
Ecstasy/XTC		Cocaine or crack	
Ever	40.7	Ever	36.1
Last 6 months	23.8	Last 6 months	16.4
High during sex last 6 months	11.9	High during sex last 6 months	5.4
LSD/Hallucinogens		Downers/Barbiturates	
Ever	45.2	Ever	14.9
Last 6 months	13.2	Last 6 months	7.8
High during sex last 6 months	4.1	High during sex last 6 months	2.0
Special K		Heroin	
Ever	15.6	Ever	4.8
Last 6 months	6.5	Last 6 months	0.9
High during sex last 6 months	2.4	High during sex last 6 months	0.6
GHB		Injected drugs	
Ever	10.6	Ever	5.2
Last 6 months	4.6	Last 6 months	1.3
High during sex last 6 months	1.3		

*Not including crystal or cocaine

Table 6. Health history among Seattle-King Co. YMS 2 participants

Heath history	Total N=462 %	Heath history	Total N=462 %
Source of regular health care (any)		Hepatitis B vaccination	
Health Maintenance Organization (HMO)	28.6	Yes - completed series	32.5
Physician's office/non-HMO group practice	22.5	Yes - did not complete series	6.9
Community health clinic	5.8	Hepatitis A vaccination	
Hospital	4.3	Yes - completed series	21.0
Other	6.9	Yes - did not complete series	6.9
No regular source of health care	31.8	Received HIV testing	
Ever had a sexually transmitted disease		Ever	91.1
Yes	25.8	In the last 6 months	33.2

Table 7. Prevalence of sexually and parenterally transmitted infections among Seattle-King Co. YMS 2 participants

Serologies	Total N=462 % reactive
HIV (anti-HIV+)	4.8
Syphilis	0.4
History of hepatitis B infection (anti-HBc+)	18.5
Chronic hepatitis B infection (HBsAg+)	1.5
Hepatitis B immunity (anti-HBs+)*	40.0
Hepatitis A immunity (IgG+)*	28.1
Hepatitis C (anti-HCV+)	0.9

*Either as a result of natural infection or vaccination

past infection or vaccination. Twenty-eight percent were positive for hepatitis A antibodies due to prior infection or vaccination; 50% of these young men reported either a complete or a partial HAV vaccination series. Four (less than 1%) were seropositive for hepatitis C, 2 of whom reported a history of injection drug use. Only 2 participants tested positive for syphilis. Seventy percent of all participants returned for their test results.

Comments

Results from this survey show that the majority of participants had multiple recent sex partners, many of whom were new sex partners. Because this survey did not ask about condom use with specific partners, we do not know whether participants with multiple recent partners, who reported not always using condoms, reserved their condom use for sex with casual partners. It was encouraging to find that a

higher proportion of men with multiple sex partners reported using condoms during anal sex "sometimes" or "always" than those with fewer partners. Interestingly, one of the more common reasons for not always using a condom among participants with 2 or more recent partners was "being in a mutually-faithful relationship." This response along with the high proportion of participants who reported several recent steady and non-steady partners suggest short-term, serially monogamous relationships were common. Because these relationships were generally short-lived, HIV status may not have been determined or even discussed, and these young men may be at higher risk for HIV and other STDs than they perceive.

The prevalence of alcohol and drug use was high. In comparison, the 1998 National Household Survey on Drug Abuse (NHSDA) conducted by the Substance Abuse and Mental Health Services Administration found that 50% of

young adults 21-29 years of age reported having used drugs at least once in their life and that 11% were current users (used in the last month). Almost three-quarters reported being high or buzzed on alcohol or drugs during sex in the past 6 months and this was also cited as a reason for unprotected sex among over a quarter of the participants with recent multiple partners.

The prevalence of HIV among these 23-29 year old men (5%) was over twice the prevalence found among the 15-22 year old men surveyed in Phase 1 (2%) indicating that HIV transmission continues to occur among MSM in their twenties. The difference in HBV (anti-HBc) prevalence was even more striking. Only 5% of Phase 1 participants had markers of prior HBV infection compared to 19% of Phase 2 participants. A minority of participants reported HAV and HBV vaccination indicating the ongoing need to promote vaccination by educating both young gay men as well as their health care providers.

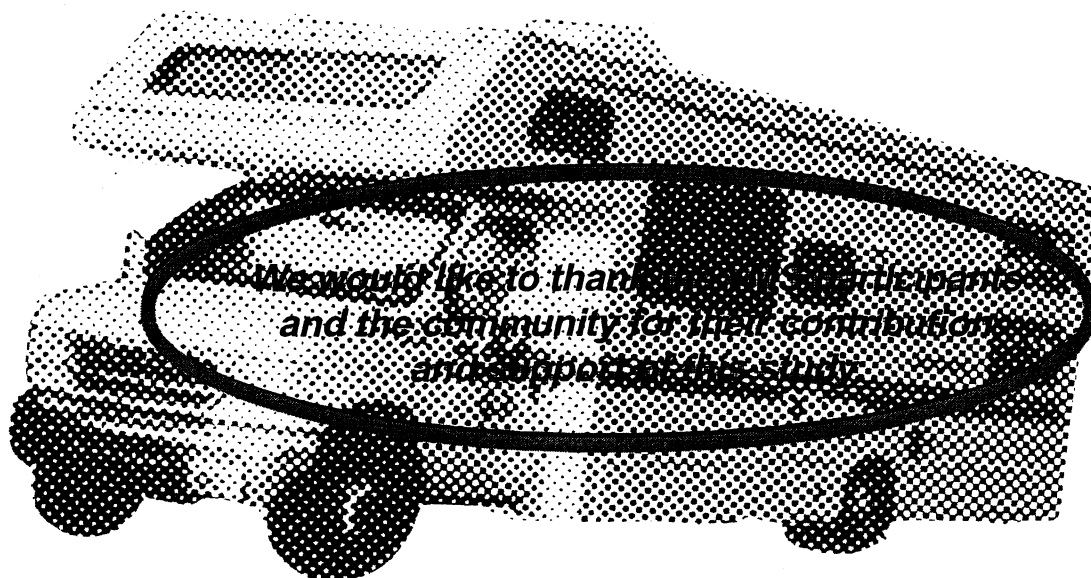
As of this writing, data collection was still underway at the other YMS sites and results for comparisons were therefore not available.

In summary, our results demonstrate the continued need for effective education and prevention efforts among younger MSM in the Seattle-King County area focusing on 1) safer sex practices including perceived safety of brief serial monogamous relationships, 2) the risk contributed by drug and alcohol use, and 3) increasing HAV and HBV vaccination rates.

Please contact Hanne Thiede (hanne.thiede@metrokc.gov) at (206)296-8663, or Tom Perdue (tom.perdue@metrokc.gov) at (206)205-7357 if you have questions about the Young Men's Survey.

□ Contributed by Contributed by Hanne Thiede DVM, MPH, Tom Perdue MPH and the YMS Phase 2 Team (Stanley Brown, Russell Campbell, Jennifer Davis, Jan Fields, Justin Haines, Damon Jameson, Barry Kosloff, David Miller, Jason Naki, Richard Newman, Dana White, Misha Williams, and Robert Yoon).

¹MacKellar D, Valleroy, Karon J, Lemp G, Janssen R. The Young Men's Survey: Methods for estimating HIV seroprevalence and risk factors among young men who have sex with men. **Public Health Rep** 1996;111:138-144.



**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 6

**ACRONYMS AND
GLOSSARY**

COMMON ACRONYMS IN HIV PREVENTION AND COMMUNITY PLANNING

ADA	Americans with Disabilities Act
AED	The Academy for Educational Development
AIDSNETS	Regional AIDS Service Networks
AKA	Also Known As
AMA	American Medical Association
APDP	AIDS Prescription Drug Program
APHA	American Public Health Association
ARNP	Advanced Registered Nurse Practitioner
ASO	AIDS Service Organization
ASTHO	Association of State and Territorial Health Officials
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community-Based Organization
CDC	Center for Disease Control and Prevention
CFH	Community and Family Health
CLI	Community-Level Intervention
CP	Community Planning
CPLS	Community Planning Leadership Summit
CRI	Community Resource Inventory
C/T	Counseling and Testing Services
CTRPN	Counseling, Testing, Referral and Partner Notification
DASA	Division of Alcohol and Substance Abuse Services (DSHS)
DOH	Department of Health
DOL	Washington State Department of Licensing
DSHS	Department of Social and Health Services
EIP	HIV Early Intervention Program
EPI PROFILE	Epidemiologic Profile
ESD	Educational Service District
G/L/B/T/Q	Gay, Lesbian, Bisexual, Transgender, Questioning (Youth)
GACHA	Governor's Advisory Council on HIV/AIDS
GLI	Group-Level Intervention
HAPDEU	HIV/AIDS Project Development and Evaluation Unit (UW)
HCPI	Health Communication and Public Information
HD	Health Department
HERR	Health Education and Risk Reduction
HOPWA	Housing Options for People with AIDS
HRSA	Health Services Resources Administration (Ryan White)
HBV/HCV/HAV	Hepatitis B Virus/Hepatitis C Virus/Hepatitis A Virus
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organizations
IDRH	Infectious Disease and Reproductive Health (DOH)
IDU	Injection Drug User
IHS	Indian Health Service
ILI	Individual-Level Intervention
IOM	Institute of Medicine

KABBS	Knowledge, Attitude, Beliefs and Behaviors Survey
L&I	Washington State Department of Labor and Industries
LHD/LHJ	Local Health Department or District/Local Health Jurisdiction
MCH/CAG	Maternal and Child Health/Consumer Advisory Group
MCH/HIV	Maternal and Child Health/HIV Workgroup
MMWR	Morbidity and Mortality Weekly Report
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men and are Injection Drug Users
NAPWA	National Association of People with HIV/AIDS
NASTAD	National Alliance of State and Territorial AIDS Directors
NGO	Non-Government Organization
NIH	National Institutes of Health
NMAC	National Minority AIDS Council
NNAAPC	National Native American AIDS Prevention Center
NWAETC	Northwest AIDS Education and Training Center
NWAF	Northwest AIDS Foundation
(O)PES	(Office) of HIV Prevention and Education Services (DOH)
OSPI	Office of the Superintendent of Public Instruction
PCAF	Pierce County AIDS Foundation
PCM	Prevention Case Management
PCRS	Partner Counseling Referral Services
PHIP	Public Health Improvement Plan (DOH)
PHS	Public Health Service
PIR	Parity, Inclusion and Representation
PNRS	Partner Notification and Referral Services
POCAAN	People of Color Against AIDS Network
PSE	Public sex environment
QA	Quality Assurance
RCW	Revised Code of Washington
RFP/RFA	Referral for Proposal or Referral for Application
RPG	Regional Planning Group
RWCA I, II, III, IV, V	Ryan White Care Act I, II, III, IV, V
SAMHSA	Substance Abuse and Mental Health Services Administration
SAN	Spokane AIDS Network
SBOH	State Board of Health
SCO	Street and Community Outreach
SPG	Washington State Planning Group
TA	Technical Assistance
WAC	Washington Administrative Code
WSALPHO	Washington State Association of Local Public Health Officials

GLOSSARY OF HIV PREVENTION AND COMMUNITY PLANNING TERMS

(The following list of terms is provided to clarification of names, acronyms and jargon most often associated with HIV prevention planning. This list is neither exhaustive nor all-inclusive. If you see errors, omissions or other problems, please let Nancy Hall (nancy.hall@doh.wa.gov) know. All website addresses were current when published.)

Academy for Educational Development (AED) – National prevention and technical assistance provider. <http://www.aed.org/>

AIDS Education and Training Center (AETC) – CDC funded technical assistance organization through the University of Washington. See NW AIDS Education and Training Center.

AIDS Prescription Drug Program (APDP) - Washington State Department of Health program which pays, primarily through Ryan White II funds, for HIV related drugs for Washington State residents who are HIV positive and have a low to moderate income.

American Medical Association (AMA)
<http://www.ama-assn.org/>

American Public Health Association (APHA)
<http://www.apha.org/>

AIDS Service Organization (ASO) - provides a variety of HIV related services for the community, which may include: case management, support, health services, education, prevention, housing, advocacy, intervention, information, referral, etc.

Association of State and Territorial Health Officials (ASTHO)
<http://www.astho.org/>

Behavioral Risk Factor Surveillance System (BRFSS) - a telephone survey developed by CDC to collect data on health risk behaviors that is useful for planning, initiating, supporting and evaluating health promotion and disease prevention programs.

Community-Based Organization (CBO) – Typically a private not for profit organization that provides services to locally defined areas, populations or issues. These may or may not include HIV issues or services.

Center for Disease Control and Prevention (CDC)
<http://www.cdc.gov/>

Community and Family Health (CFH) - a division of the Department of Health in which HIV services is included.

Community-Level Intervention (CLI) - Interventions designed to affect/change social norms to increase support of behaviors known to reduce the risk of HIV transmission. One of the intervention categories designated by CDC under HERR.

Community Planning (CP) – a mandated, formal process implemented in 1993 by which local and state-wide HIV prevention populations and effective intervention priorities are established through the development of the comprehensive HIV prevention plan. Through a diverse membership, reflecting those infected/affected by the HIV epidemic, experts in the fields of HIV and behavioral prevention and epidemiology and partners from community-based organization and health departments, the planning group(s) must assure that as many voices and viewpoints are considered as possible in the formulation of the priorities and in reaching concurrence with the disposition of resources.

Community Planning Leadership Summit (CPLS) – The annual meeting (sponsored by NMAC (National Minority AIDS Council) to bring together the co-chairs, technical assistants, AIDS service organizations (ASO), health departments and others involved in the HIV prevention planning process.

Community Resource Inventory (CRI) - an inventory of the HIV prevention services currently available in each AIDSNET region.

Counseling and Testing Services (C/T) - HIV testing and counseling. A CDC identified intervention category of services,

Counseling, Testing, Referral and Partner Notification (CTRPN) - older term for the combination of HIV test counseling, referral and partner notification.

Ellensburg Document (Agreement) – An agreement between the AIDSNETs, DOH, the SPG and the RPGs on the roles and responsibilities of the 4 partners in the HIV prevention planning process.

Epidemiologic Profile (Epi Profile) - a document, prepared by the Washington DOH, that identifies HIV-infected and populations at high risk for HIV infection in Washington State and the six AIDSNET regions. Required statistical documentation for HIV prevention planning.

Educational Service Districts (ESD) - serve school districts and state approved private schools within specific service areas. ESDs function primarily as support agencies and deliver educational services that can be more efficiently or economically performed regionally.

Evergreen AIDS Foundation - offers a continuum of services from outreach and prevention/education to direct care and support services for people with HIV/AIDS in Whatcom and Skagit County. <http://www.evergreenaids.org>

Gay, Lesbian, Bisexual, Transgender, Questioning Youth (G/L/B/T/Q)

Governor's Advisory Council on HIV/AIDS (GACHA) – State level group appointed by and advisory to the Governor.

Group-Level Intervention (GLI) - Interventions designed to serve groups of varying sizes. A CDC identified category of HIV prevention (HERR).

HIV Early Intervention Program (EIP) - Washington State Department of Health program which pays for insurance premiums and HIV related medical, dental and laboratory services for Washington State residents who are HIV positive and have a low to moderate income.

HIV/AIDS Project Development and Evaluation Unit (HAPDEU) - a part of the University of Washington's School of Social Work. Provides technical assistance and state-wide over-sight and evaluation of the Friend to Friend project, a community-level intervention (CLI) for MSM.

Health Communication and Public Information (HCPI) – A CDC intervention category that includes mass media, other media, social marketing, hotlines and clearinghouse services and provides primarily educational information and services.

Health Education and Risk Reduction (HERR) – A CDC intervention category that includes individual-level interventions, group-level interventions, community-level interventions and street and community outreach that are targeted to people and populations at risk of HIV infection or transmission.

Health Services Resources Administration (HRSA) – Federal agency responsible for administering the Ryan White Care Act funds.
<http://www.hrsa.gov>

Housing Options for People with AIDS (HOPWA) – Federal housing assistance program for people with HIV/AIDS, administered by the U.S. Department of Housing and Urban Development (HUD).
<http://www.hud.gov/cpd/hopwahom.html>

Indian Health Service (IHS) – Federal agency that oversees or provides health services to American and Alaska Indian tribes and individuals.
<http://www.ihs.gov>

Individual-Level Intervention (ILI) – A CDC Intervention category designed to serve one client at a time for the prevention of HIV transmission.

Infectious Disease and Reproductive Health (IDRH) - an office of Community and Family Health (DOH).

Institute of Medicine (IOM) – National organization.
<http://www.iom.edu>

Intervention – any organized activity designed to influence knowledge, attitudes, beliefs or behaviors related to the prevention of HIV/AIDS. CDC defines the categories of interventions as: Health Education/Public Information (HC/PI); Health Education/Risk Reduction (HERR); Counseling and Testing, Referral and Partner Counseling Service (CTRPCS, used to be CTRPN). Under the provisions of the Ellensburg Agreement, 100% of the CDC funded interventions and 50% of the Omnibus funded interventions must be allocated to the population and effective intervention priorities established in the comprehensive HIV prevention plan.

KNOW Curriculum - a compendium of the minimal elements needed to provide comprehensive education about HIV. Available from Washington HIV Prevention and Education Services - (800) 272-2437 (Hotline).

Knowledge, Attitude, Beliefs and Behaviors Survey (KABBS) – A research survey periodically conducted by the Washington DOH for the purpose of identifying HIV knowledge, attitudes, beliefs and behaviors in the general and identified sub-populations.

Maternal and Child Health/Consumer Advisory Group (MCH/CAG) – Consumer Advisory Group to the Community and Family Health Maternal and Child Health/HIV Workgroup at Washington DOH.

Morbidity and Mortality Weekly Report (MMWR) - Publication by CDC that includes data and reports on infectious and chronic diseases.
<http://www.cdc.gov/mmwr/>

National Association of People with HIV/AIDS (NAPWA)
<http://www.napwa.org/>

National Alliance of State and Territorial AIDS Directors (NASTAD)
<http://www.nastad.org/>

National Institutes of Health (NIH)
<http://www.nih.gov/>

National Minority AIDS Council (NMAC)
<http://www.nmac.org/>

National Native American AIDS Prevention Center (NNAAPC)
<http://www.nnaapc.org/>

Northwest AIDS Education and Training Center (NWAETC) - funded by HRSA to support the training of physicians, physician assistants, nurses, nurse practitioners, dentists, clinical pharmacists and other health care providers in the treatment and management of HIV/AIDS.

<http://weber.u.washington.edu/~nwaetc/>

Northwest AIDS Foundation (NWAf) – Community-based organization that provides and advocates for quality of life services for people living with HIV and AIDS, prevention of the spread of HIV, and to advocating for all those whose lives have been affected by HIV and AIDS. Serves primarily the greater Seattle area with some state-wide programs.

<http://www.nwaims.org/>

(Office) of HIV Prevention and Education Services (OPES) - a section of the Community and Family Health Division (CFH) of the Washington Department of Health.

<http://www.doh.wa.gov/cfh/hiv.htm>

Office of the Superintendent of Public Instruction (OSPI) - works with the state's 296 school districts to administer basic education programs on behalf of more than one million students in Washington's public and private schools.

<http://www.k12.wa.us/>

Parity, Inclusion and Representation (PIR) - developed in accordance with CDC objectives for community planning - attempts to assure that all members of the HIV prevention community planning group have equal opportunity for input and participation as well as equal voice in voting and other decision-making activities (parity); assurance that all affected communities are represented and involved in a meaningful manner in the community planning process (inclusiveness); and assurance that those who are representing a specific community truly reflect that community's values, norms and behaviors (representation).

Partner Counseling Referral Services (PCRS) – redefined CDC intervention category that includes working with HIV-infected clients to identify their sex and needle-sharing partners. It also involves locating those partners, notifying them that they may have been exposed to HIV and offering them counseling, testing, and other referrals.

Partner Notification and Referral Services (PNRS) - older CDC term that has been replaced by PCRS.

People of Color Against AIDS Network (POCAAN) - a multi-racial community-based AIDS prevention organization created in response to the devastating impact that HIV/AIDS was and continues to have on communities of color. POCAAN seeks to remove the barriers created by sexism, racism and

homophobia, which limit our abilities to access health care services and educational risk reduction messages concerning AIDS.
<http://www.pocaaan.org/>

Pierce County AIDS Foundation (PCAF)- offers a variety of services for persons living with HIV/AIDS, including case management, assistance for basic needs, support groups, advocacy. Provides services primarily in the Pierce county area.
<http://www.piercecountyaims.org/>

Prevention Case Management (PCM) – A CDC defined prevention intervention for HIV-positive individuals.

Public Health Improvement Plan (DOH) – a published and updated plan addressing the health and safety of citizens in Washington. Available through the DOH website: <http://www.doh.wa.gov>

Public sex environment – sites, places and locations where the public can access sex, i.e. adult bookstores, adult video shops, bathhouses, known cruising areas in parks, public restrooms, etc.

Regional AIDS Service Networks (AIDSNETS) - Six regional districts established to administer The HIV/AIDS prevention and care efforts. The largest Local Health Department/District in each region was designated as the lead. The Regions are:

Region 1: Spokane Health District, lead. Includes: Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Stevens, Spokane, Whitman and Walla Walla counties.

Region 2: Yakima Health District, lead. Includes: Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima counties.

Region 3: Snohomish Health District, lead. Includes: Island, San Juan, Skagit, Snohomish and Whatcom counties.

Region 4: Public Health-Seattle King County, lead. Includes King county.

Region 5: Tacoma-Pierce County Health Department, lead. Includes: Bremerton and Pierce counties.

Region 6: Southwest Washington Health District, lead. Includes: Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum counties.

Referral for Proposal or Referral for Application (RFP/RFA) – Announcement issued by government agency to request applications for competitive funds to provide specified services.

Regional Planning Group (RPG) - Community planning group in each AIDSNET region that identify and prioritize HIV prevention needs for their respective region and issue an annual comprehensive HIV prevention plan.

Revised Code of Washington (RCW) – The laws that govern all governmental and associated activities in the state.

Ryan White Care Act I, II, III, IV, V (RWCA I, II, III, IV, V) - Program which is administered by the HHS Health Resources Services Administration (HRSA) that supports systems of care for people with AIDS who do not have adequate health insurance or other resources.
<http://www.hivdent.org/funding.htm>

Spokane AIDS Network (SAN) - a community based agency dedicated to minimizing the impact of, and maximizing awareness about, AIDS and other consequences of HIV infection on communities and individuals in the Inland Northwest
<http://www.spokaneaidsnetwork.org/>

State Board of Health (SBOH)- established by the State Constitution in 1889. Its ten members are appointed by the Governor to represent the people of the State. Terms of service are staggered to assure both continuity and fresh perspective. The Board's mission is to develop policies to promote, protect, maintain, and improve the health of Washingtonians.
<http://www.doh.wa.gov/SBOH/>

Street and Community Outreach (SCO) – A CDC category of HERR interventions that involves finding, providing and referring at-risk persons to prevention services at locations where those persons are found in the community.

Substance Abuse and Mental Health Services Administration (SAMHSA)
<http://www.samhsa.gov/>

U.S. Department of Health and Human Services (HHS)
<http://www.hhs.gov>

U.S. Public Health Service (PHS)
<http://phs.os.dhhs.gov/phs/>

Washington Administrative Code (WAC) – the rules by which government and associated organizations do business.

Washington State Department of Labor and Industries (L&I)
<http://www.wa.gov/lni/>

Washington State Association of Local Public Health Officials (WSALPHO)

Washington State Department of Health (DOH)
<http://www.doh.wa.gov/>

Washington State Department of Social and Health Services (DSHS)
<http://www.wa.gov/dshs>

Washington State Division of Alcohol and Substance Abuse Services (DASA) - a
division of the Department of Social and Health Services

Washington State Planning Group (SPG) - Statewide HIV Prevention Community
Planning group responsible for providing guidance and statewide planning for
HIV prevention..

**WASHINGTON STATE
HIV PREVENTION PLAN**

ATTACHMENT 7

LITTLE BLUE BOOK

For more information about the
State Planning Group (SPG)
contact the following:

WA State Dept. of Health
HIV Prevention and
Education Services
1-800-272-2437

For more information about
your Regional Planning Group
(RPG), contact:

**An Orientation to
Community Planning for
HIV Prevention**

THE LITTLE BLUE BOOK

(2001 DRAFT)

Personal Checklist

NOTES

This checklist can help you determine your readiness to actively participate in the planning process.

- _____ I understand the basic elements of the planning process as outlined by the side-by-side guidance.
- _____ I know when and where the next meeting of the planning group is being held.
- _____ I have received my copy of the *Big Book* and a disk copy of the *Big, Big Book*.
- _____ I have reviewed the planning group charter.
- _____ I have been instructed in how to receive a reimbursement for incurred expenses.
- _____ I understand my role in the planning process.
- _____ I have received a copy of the Acronym and Glossary of HIV/AIDS terms.
- _____ I understand how to request further information, training and technical assistance.
- _____ I know what to expect at meetings and have reviewed the ground rules.
- _____ I have attended an orientation meeting.
- _____ I know the difference between the annual HIV prevention plan and the CDC application for funding.

1

SAN
SBOH
SCO
SPG
TA
WAC
WSALPHO

Spokane AIDS Network
State Board of Health
Street and Community Outreach
Washington State Planning Group
Technical Assistance
Washington Administrative Code
Washington State Association of Local Public Health
Officials

NOTES

WELCOME TO COMMUNITY PLANNING

A Letter for DOH Assistant Secretary Jack
Williams – to be added

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		NASTAD	National Alliance of State and Territorial AIDS Directors
		NIH	Non-Government Organization
		NMAC	National Institutes of Health
		NNAAPC	National Minority AIDS Council
		NWAETC	National Native American AIDS Prevention Center
		NWAF	Northwest AIDS Education and Training Center
		(O)PES	Northwest AIDS Foundation
		OSPI	(Office) of HIV Prevention and Education Services (DOH)
		PCAF	Office of the Superintendent of Public Instruction
		PCM	Pierce County AIDS Foundation
		PCRS	Prevention Case Management
		PHIP	Partner Counseling Referral Services
		PHS	Public Health Improvement Plan (DOH)
		PIR	Public Health Service
		PNRS	Parity, Inclusion and Representation
		POCAAN	Partner Notification and Referral Services
		QA	People of Color Against AIDS Network
		RCW	Quality Assurance
		RFP/RFA	Revised Code of Washington
		RPG	Referral for Proposal or Referral for Application
		RWCA I, II, III, IV, V	Regional Planning Group
		SAMHSA	Ryan White Care Act I, II, III, IV, V
			Substance Abuse and Mental Health Services Administration

COMMON ACRONYMS IN HIV PREVENTION AND COMMUNITY PLANNING

ADA	Americans with Disabilities Act
AED	The Academy for Educational Development
AIDSNETS	Regional AIDS Service Networks
AKA	Also Known As
AMA	American Medical Association
APDP	AIDS Prescription Drug Program
APHA	American Public Health Association
ARNP	Advanced Registered Nurse Practitioner
ASO	AIDS Service Organization
ASTHO	Association of State and Territorial Health Officials
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community-Based Organization
CDC	Center for Disease Control and Prevention
CFH	Community and Family Health
CLI	Community-Level Intervention
CP	Community Planning
CPLS	Community Planning Leadership Summit
CRI	Community Resource Inventory
C/T	Counseling and Testing Services
CTRPN	Counseling, Testing, Referral and Partner Notification
DASA	Division of Alcohol and Substance Abuse Services (DSHS)
DOH	Department of Health
DOL	Washington State Department of Licensing
DSHS	Department of Social and Health Services
EIP	HIV Early Intervention Program
EPI	Epidemiologic Profile
PROFILE	
ESD	Educational Service District
GI/BI/T/Q	Gay, Lesbian, Bisexual, Transgender, Questioning (Youth)
GACHA	Governor's Advisory Council on HIV/AIDS
GLI	Group-Level Intervention
HAPDEU	HIV/AIDS Project Development and Evaluation Unit (UW)
HCPI	Health Communication and Public Information
HD	Health Department
HERR	Health Education and Risk Reduction
HOPWA	Housing Options for People with AIDS
HRSA	Health Services Resources Administration (Ryan White)
HBV/HCV/	Hepatitis B Virus/Hepatitis C Virus/Hepatitis A Virus
HAV	

Purpose of Community Planning

Together with your fellow planning group members, the AIDSNETs and the Washington State Department of Health, the planning group is charged with the development and monitoring of the HIV Prevention Plan. This plan specifically addresses your community's needs and the recommended solutions for effective HIV prevention.

How It's Done

Washington state is divided into 6 AIDSNET regions, each with it's own planning group(s). Additionally, there is a State Planning Group that provides guidance and summarization of all state planning efforts. The planning groups vary in size, meeting schedules and process, but all are responsible for the following tasks and decisions:

- Assess the extent of the HIV epidemic,
- Assess the existing prevention resources
- Identify the unmet HIV prevention needs
- Define the potential impact and effectiveness of specific prevention interventions
- Prioritize HIV prevention needs (populations and interventions)
- Develop a locally specific HIV prevention plan, and
- Evaluate the planning process.
- Determine concurrence

History of HIV/AIDS Prevention Planning and Services in Washington State

In March 1988, the Washington State Legislature passes the 1988 AIDS Omnibus Bill which created the Office on HIV/AIDS and the six regional AIDS service networks (AIDSNETS). The Bill distributed a considerable amount of funding for HIV/AIDS prevention and services throughout the state. The AIDSNETS were charged with developing a plan to meet the needs for HIV education and services within each of the regions. The plan was to reflect the cooperative effort between the local health jurisdictions (LHJ), the community-based AIDS service organizations and other appropriate governmental, non-governmental and private organizations within the region. The county with the largest LHJ in the region was designated as the lead agency. The six regions, with lead agency listed first, are:

REGION 1: Spokane Regional Health District: Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman.

REGION 2: Yakima Health District: Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat, and Yakima.

REGION 3: Snohomish Health District: Island, San Juan, Skagit, Snohomish, and Whatcom.

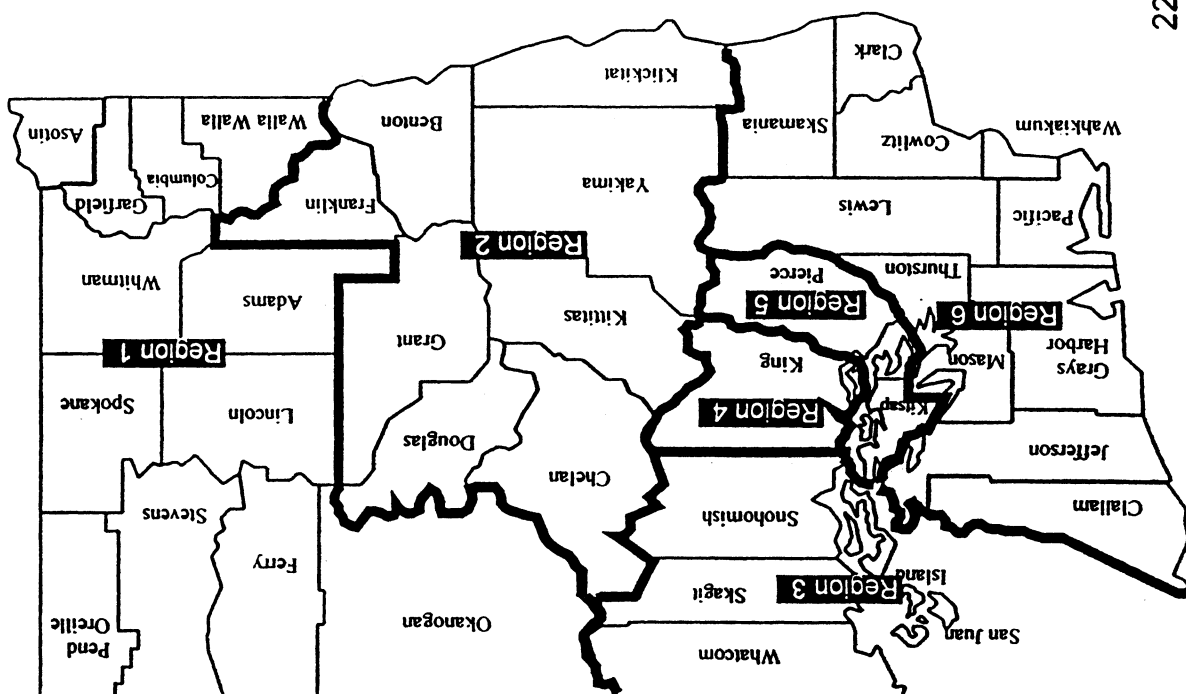
REGION 4: Public Health-Seattle and King County: King.

REGION 5: Tacoma-Pierce County Health Department: Kitsap and Pierce.

REGION 6: Southwest Washington Health District: Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum.

(See map – Page 22)

WASHINGTON STATE AIDSNET REGIONS



12. *Where does Technical Assistance (TA) come from?* Planning groups should seek TA from their health department or DOH. DOH will work with the CDC to access TA available from nationally funded technical assistance providers.
13. *Who is responsible for developing the HIV prevention budget?* Each Health department is responsible for developing the budget and administering the CDC and Omnibus HIV prevention dollars as outlined in the Ellensburg agreement. The budget must include sufficient dollars to support the HIV prevention planning group process. In addition, the health department is responsible for ensuring these dollars are awarded to contractors through an open competitive process in a timely manner and monitor the contracts to ensure contractors compliance.
14. *What are CDCs requirements about community planning groups working with other health planning processes?* CDC encourages coordination with other planning processes. At a minimum, the health department should routinely inform planning groups of related planning efforts. Planning groups must also demonstrate, in their plan, how they are linked with service for STD, TB, mental health, care planning, chemical dependency, and with community based and other organizations involved in care and treatment services.
15. *What are the advantages to planning groups coordinating with other planning groups?* Coordinating with other planning groups may facilitate the planning groups' task. For example, other groups may be able to assist in providing information about community resources, unmet needs, how primary and secondary HIV prevention is linked, and how private and government agencies are working together.

The 1988 Omnibus AIDS Bill also required that the plan address the following areas: (1) voluntary and anonymous counseling and testing; (2) mandatory testing and/or counseling as required by law; (3) notification of sexual partners and infected people; (4) education of the general public, healthcare professionals and individuals at high-risk; (5) implementation of intervention strategies for high-risk individuals; (6) outreach to runaway youth; (7) case management; and (8) a community-based continuum of care.

All of the AIDSNET regions established regional advisory and/or planning groups to provide a forum for regional planning of prevention and care activities. While no 'formal' community prevention plans were required, each region was required to develop a Regional Service Plan that reflected the outcome of the planning process. Additional planning input was developed through the AIDSNET Council (a non-legislatively mandated, voluntary coordinating group comprised of the directors of the AIDSNET lead LHJs and Washington State Department of Health), the State Board of Health, and other appropriate statewide groups.

In 1989 the Office on HIV/AIDS was moved to the newly created Washington State Department of Health and the HIV Education and Prevention Services and Client Services Programs were established.

1988 AIDS Omnibus Bill and CDC Community Planning

The 1988 Omnibus AIDS Bill established the formula allocation of HIV/AIDS state funds, and where allowable, federal and other funds for prevention and care services. Until 1994, the planning process for utilization of these formula funds was based on each regions internal process and submitted as part of the regional service plan.

CDC had been providing some base funds for HIV counseling and testing, surveillance and prevention education to states since the mid-1980s. In many states this remains the primary source of HIV/AIDS prevention funding today. Washington's own state

Omnibus funds supplemented and remain a considerably greater source of support than what is provided by the CDC. Washingtonians are fortunate to have had such a pro-active and supportive state legislature.

Within the implementation of CDC community planning guidance in 1994, each region was charged with the formation of a Regional Planning Group (RPG). The Washington State Department of Health formed the State Planning Group (SPG). To facilitate communication and action between the regional and state planning groups, each regional planning group sends three representatives to the state planning group. Additional at-large (non-regional) members were included to provide expertise, community representation and appropriate balance in the membership.

After four years of effort to mesh the AIDSNET system and the CDC community-planning model, it became evident that the system was meeting neither the needs of the region, the state or the CDC planning process. In October 1997, at the request of the SPG, DOH convened the stakeholders of community planning (co-chairs of the Regional Planning Groups, the State Planning Group, and designated representatives of the AIDSNETS and DOH), in Ellensburg, WA. The purpose of this facilitated two-day retreat was to review what was working, what wasn't working and how to improve the community planning process. The result was the Ellensburg Document.

8. *What is the relationship between the Regional Planning Group (RPG) the State Planning Group (SPG) and the State Department of Health (DOH)?* The planning process and plan is a joint effort from different areas of the state. Each region formulates a plan using epidemiological data and information gathered from community members and submits their plan to DOH. DOH supplies the epidemiological reports used in formulating the plan. DOH is also responsible for combining the six regional plans into one statewide for submission to CDC. The SPG provides guidance to complete the process and investigates and determines HIV prevention needs on a statewide basis. The SPG reviews the each regions' plans, provides feedback, and provides a Letter of Concurrence for the statewide plan.
9. *Where can I locate more information about regional or state planning?*
Call the WA State AIDS Hotline at 1-800-272-2437
10. *Do planning groups have to develop a new comprehensive plan each year?* No, multi-year plans are desirable. However, each year the group should carefully review its epidemiological profile, prioritization needs, intervention effectiveness data, and any new sources of information in order to refine, when appropriate, the goals and objectives outlined in their plan.
11. *What is technical assistance (TA)?* TA refers to the help planning groups might need to facilitate completion of the planning process. TA encompasses a wide variety of subjects, resources, and formats. Some of the major areas where TA might be helpful are as follows:
 - Parity, inclusion, and representation
 - Epidemiological profile
 - Prioritization (population)
 - Process and HIV prevention evaluation
 - Gap and cost analysis
 - Conducting a needs assessment
 - Behavioral science
 - Determining effective interventions

6. *What is the Letter of Concurrence and what does it mean?* Each planning group has the responsibility to review the health department's HIV prevention budget to ensure 100% of the CDC dollars and at least 50% of the Omnibus dollars address the priorities outlined in their plan. The planning group has three options after reviewing the proposed health department budget/plan to spend the funds. They are as follows:
 - Letter of Concurrence – this signifies the group has reviewed the health department's budget and agrees the proposed budget for spending HIV prevention dollars, successfully addresses the priorities outlined in the plan.
 - Letter of Concurrence with Reservations/Stipulations – this signifies the group has some concerns/issues with the proposed spending budget as it is written. The health department must address these issues or concerns and provide feedback to the group, the State Department of Health, and CDC.
 - Letter of Non-concurrence – this signifies the group does not feel the HIV prevention dollars in the health department's budget successfully addresses the priorities outlined in the plan.
7. *Does a Letter of Non-concurrence mean the region will lose funding?* Not necessarily. CDC and the State Department of Health may do any of the following:
 - Obtaining more information about the situation
 - Meeting with the health department and group co-chairs
 - Negotiating with the health department regarding the issues raised
 - Approving the health department's application as submitted
 - Requesting a detailed plan for corrective action to include a timeline
 - Conduct an onsite assessment visit focused of specific issues
 - Conduct an onsite comprehensive assessment and propose action to resolve areas of concern
 - Request technical assistance
 - Place conditions on the funding pending a future plan submission

Ellensburg Document and Community Planning

The Ellensburg Document delineated the roles and responsibilities of the stakeholders and was finalized in the Letter of Understanding (LOU) signed by all stakeholder groups in April 1999. Within the restraints of the 1988 Omnibus AIDS Bill, the Ellensburg Document/LOU designated that 50% of the formula Omnibus funds and, of course, 100% of the CDC funds must be targeted to the prioritized at-risk populations in the respective plan. The LOU also limited the amount of federal funds (no more than 10%) that could be allocated to statewide efforts through SPG planning. Additionally, the state planning group's role was defined in terms of the development of planning guidance and technical assistance, while the regional planning groups assumed more responsibility for prioritization and implementation of effective interventions at the community level.

This process has had a profound and long-term effect on the community planning process in Washington. The time needed to develop and implement guidance on all aspects of the planning process has been lengthy and is not yet complete. Coordinating six separate and independent regional planning groups has proved to involve a learning curve for everyone involved. Progress, however, has been steady and regional plans are beginning to reflect this commitment to quality community planning.

Through this collaborative effort of the regional planning groups, the state planning group, the Washington State Department of Health and the AIDSNETs, the planning process will result in strong and effective community-specific HIV prevention interventions.

Who's Involved?

There are many people and organizations throughout the state involved in the HIV prevention process. These include:

- **Regional Planning Group members:** people from individual communities, organizations and interests who are the voting members of the RPG. Each RPG has a Parity, Inclusion and Representation Plan to recruit and retain members who represent the infected/affected communities, experts and organizations.
- **State Planning Group members:** the SPG membership consists of 3 members appointed from each region. These 3 members should represent the health department(s), infected/affected community and community-based organizations in the respective regions. The remaining members of the SPG (12-14) are appointed by DOH as at-large members and provide membership in accordance with the PIR needs, as established by the PIR plan.
- **Co-chairs:** Each planning group has 2 co-chairs, one representing the health department(s) and the other an elected community co-chair. Some RPGs and the SPG also have an elected Vice-chair who spends one year in training before assuming the responsibility as community co-chair.
- **AIDSNET:** the lead health department in each region is the fiscal and programmatic lead for HIV prevention in the region.
- **WA State Dept. of Health (DOH):** DOH is the jurisdictional lead for the CDC application and funding for HIV prevention. It is their role to assure that the requirements and process of community planning are met throughout the state by providing technical assistance and support to the SPG and RPGs.

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ANSWERS TO QUESTIONS

To assist in understanding community planning, following are some of the most frequently asked questions concerning the community planning process.

1. *What is community planning?* Community planning is the process used by each region and the state to determine which populations of special emphasis should be targeted with public funds for HIV prevention.
2. *What are Omnibus dollars?* The Omnibus Bill of 1988 included state funding for HIV prevention activities. In 2001, \$8.1 million in Omnibus funds go to AIDSNETS for HIV prevention, case management and coordination of activities.
3. *What is the Regional AIDS Service Network?* The Regional AIDS Network or AIDSNET is a county or a group of counties charged with planning and coordinating HIV/AIDS services funded by the Omnibus Act. The Omnibus Act listed the services that must be provided within the region, but not the level of services. The legislation required the Department of Health to designate six AIDSNETs in the state.
4. *What are the six regions?* The lead agency within each region is noted with an asterisk. Region 1: *Spokane Regional Health District; Region 2: *Yakima Health District; Region 3: *Snohomish Health District; Region 4: *Public Health Seattle-King County; Region 5: *Tacoma-Pierce County Health Department; and Region 6: *Southwest Washington Health District.
5. *What assurance do I have money received by the region is spent for HIV prevention?* IN 1997, a statewide committee met in Ellensburg to discuss spending HIV prevention dollars. The committee made several recommendations. One of the most important was the stipulation that each region must ensure 100% of the CDC dollars and at least 50% of the Omnibus dollars address priorities outlined in the Regions' HIV prevention plan. The Letter of Concurrence for the region/state, which accompanies the plan to CDC signifies compliance.

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(match) between the priorities established in the prevention plan and the allocations established by DOH or the ADISNET/LHJ. (see page 19, Question 6 for details).

Getting Started

As you get ready to participate in the community planning process there are some things that may help you feel more comfortable and ready to participate. These include:

- Read as much of the guidance, charter and other information you received before coming to the meeting.
- Read your job description.
- If you have questions, call one of the co-chairs or identified staff for clarification and answers.
- If you receive an information packet prior to the meeting, thoroughly review it and ask questions, if needed, about the contents.
- Refer to your acronym and glossary list to help make the many technical terms more understandable.
- You will probably hear lively discussion and debate. Sharing opinions is an important part of community planning. You will be welcome to advocate for your ideas right off the bat!!
- You will not be expected to share personal information during any discussion. Please remember to protect your own privacy and personal boundaries.
- Unless there are clear procedures and consent, no pictures or recordings (except for purposes of minutes by recording secretary) may be made of the meetings, and
- All members and participants will be expected to adhere to the established ground rules.

Group Member Job Description

The following job description is provided to give you an idea about the role and responsibilities of group members of the planning groups. There may be responsibilities and roles in your planning group that are different, based on your charter, but this description generally applies to all planning groups.

As a member of a planning group, it is your role to:

- Make a commitment to this process and its results,
- Participate in all decisions and problem solving,
- Attend all meetings, if possible,
- Participate in committees, trainings, technical assistance and other opportunities, whenever possible,
- Spread the word about the planning process.
- Represent community perspective.

The length of commitment is outlined in the planning group charter. Some planning groups do have term and membership limits, others do not.

The estimated time involved varies with each planning group, but usually involves a minimum of 2-8 hours per month for the planning group meeting or other committee work. Additional hours may be required for travel, preparation and training opportunities.

Major tasks for all members include:

1. Becoming familiar with the *CDC Guidance for Community Planning*. Available in your 'Big Book.'
2. Reviewing, getting clarification and understanding the basic elements of the Epi Profile, needs assessment data, prevention and interventions needs of targeted populations and other elements of the decision making process.
3. Participating in the prioritization and recommendation process of the planning group.

4. Becoming familiar with the characteristics and potential use of effective interventions, including: Counseling and Testing; Partner Counseling and Referral Services; Individual Level, Group Level and Community Level Interventions; Street and Community Outreach; Prevention Case Management and Health Communication/Public Information.

5. Participating in the evaluation process to improve the planning process.

Co-chair Job Description

Each planning group has a health department and community co-chair. The health department co-chair is usually regional or department staff directly responsible for HIV prevention and services. The Community co-chair is an elected position and shares the duties of co-chair with the health department co-chair. These duties usually include:

- Developing the agenda for each meeting
- Reviewing the minutes of each meeting
- Co-chairing each meeting
- Providing leadership to assure the planning process proceeds and achieves its goal of an HIV Prevention Plan
- Sign any planning group correspondence
- Sign any Letters of Concurrence, Partial Concurrence or Non-concurrence to DOH or CDC, as appropriate
- Chairing specifically determined committees
- Managing and resolving planning group conflicts, and
- Advocating for the work of the planning group.

The length of the community co-chairs term is outlined in the planning group charter

The duties of the co-chair will determine the time requirements of the position, but usually exceeds the basic member time by 6-8 hours per month.

4. Effective Interventions

Each planning group must determine a prioritized list of effective interventions for the at-risk populations. These interventions should be scientifically and behaviorally proven to meet the needs of the population served and result in changes that reduce the transmission of HIV. If no proven interventions are known or deemed appropriate, then unproven programs can be used, if there is a strong commitment to evaluation of effectiveness. Remember that when the HIV prevention plan is written, it must cite the reasons why you expect a particular intervention to work among the identified population.

5. Priority Setting

Using the Epi Profile and other supporting documentation, the planning group will need to set the priorities for HIV prevention in the region. (The SPG will set the behavioral risk category priorities for the state). The priorities and gap analysis will establish those needs and interventions that should be supported by available resources. DOH and LHJs make the final funding decisions.

6. Writing the Plan

Putting it all together. Each planning group is responsible for approving the final written document, the *HIV Prevention Plan*, for your region. This document may have been written by members of the planning group, support staff or other identified people, but the final plan must be the product of an approval process by the entire group. Once the regional plan is complete, a statewide plan is developed by DOH and approved by the SPG. This state plan becomes the basis for submission of the CDC application.

7. Evaluation

Each planning group must evaluate the planning process to suggest ways to improve the process in the following year.

8. Concurrence

Each planning group must determine the degree of congruence

The Basic Steps of the Planning Process

1. Epidemiologic (Epi) Profile

In order to assess the extent of the HIV epidemic in your area, an Epi Profile will be developed by either the local health jurisdiction or DOH assessment office. This Epi Profile will contain the important statistical and supplemental information needed to develop a portrait of the HIV epidemic over the years and the populations at-risk. These information will have been gathered from a wide range of sources including disease reporting, surveillance, interviews, focus groups, surveys, community hearing and meetings, other related statistical information and markers and local, statewide and national reports. An expert in the field of epidemiology and assessment will facilitate presentation and discussion of this information.

2. The Resource Inventory

Each planning group will compile a resource inventory. This information may be generated through the SHARE (Statewide HIV Activity, Reporting and Evaluation) data collection system for those interventions funded through targeted CDC or Omnibus funds. For other resources, it is common for planning groups to survey the service providers. Regardless of the source of the information, the Resource Inventory should answer the question: "Who is doing what for whom in HIV prevention and how are those services delivered?". A final questions may be "At what cost?"

3. Gap Analysis

Each planning group must be able to clearly define the *needs* of the at-risk populations in their region. Using the information collected about the *resources* available to meet these needs, the planning groups can determine those needs that are not being met. Through a decision making process, these *unmet needs* can be prioritized and effective interventions can be identified. Analysis of the differences between the present utilization of resources and the priorities may identify gaps in services. This analysis may result in a shift in resources to fill identified gaps.

Additional roles and responsibilities of members, co-chairs, regional planning groups, state planning group, DOH and AIDSNETs are outlined in the Ellensburg Document. This document is available to anyone by request to the offices listed on the back of this pamphlet or in your membership materials.

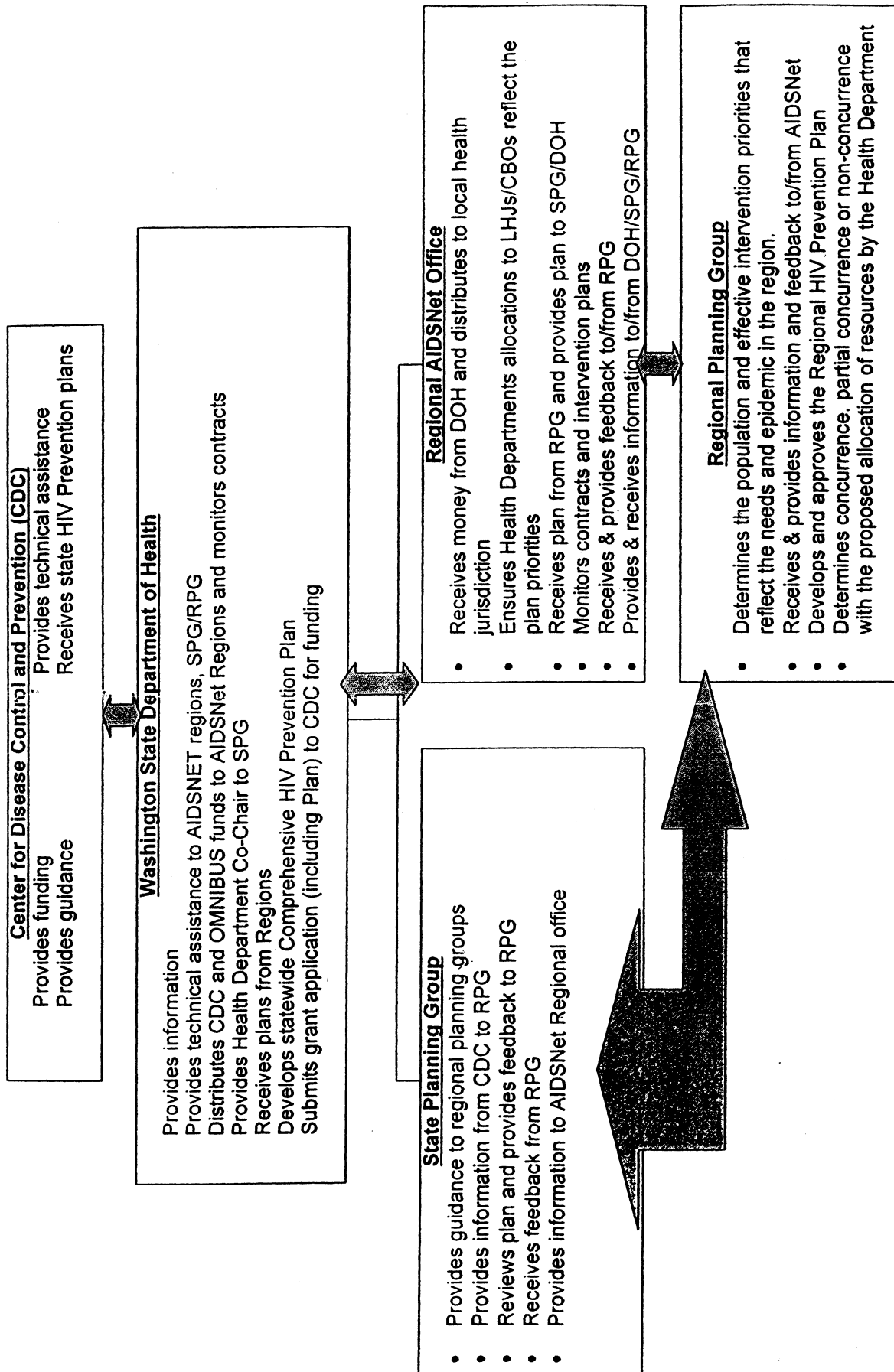
Benefits of Membership on a Planning Group

The greatest benefit of being a member of a planning group is that you are an active participant in the future of HIV prevention in your community, organization and life. Your voice becomes one of so many dedicated and active community planners throughout the state and nation. YOU CAN MAKE A DIFFERENCE!!!!!!!!!!!!

You will personally benefit from being a member of a planning group through your own increase in knowledge, the opportunity to work with a diverse and dedicated group of people and the feeling a satisfaction that you have both participated and assured as job well done. YOU ARE THE DIFFERENCE!!!!!!!!!!!!!!

And, finally, you should not need to be denied access to this process due to constraints of money or support. All planning groups have a mechanism for reimbursing out-of-pocket expenses related to attending meetings and other opportunities. These reimbursements may include travel/mileage costs, childcare costs, lodging and meals (if required) and other approved costs.

INFORMATION FLOW



This flow chart does not give all the information sharing which occurs between these separate entities. It is intended to give you some idea concerning the flow of information which may occur. The most important thing to remember is the communication flows both ways.